Decision Making in a Multi-agency Team

A Thesis submitted to the University of Manchester for the
Degree of Doctor of Educational Psychology (DEdPsy) in the
Faculty of Humanities

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School of Education
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ABSTRACT

Every time a practitioner in children’s services offers a child and their family an intervention a decision or decisions has to be made. However the decision making process in children’s services has rarely been studied. Decision making has been extensively studied in other disciplines in both laboratory and real life situations. A dual process model has been proposed consisting of a fast, automatic, intuitive system and a slower reflective system. The two systems are deemed to work best in different situations and have their own strengths and weaknesses. Decision making in complex situations, such as those involving children and families, involves both types of processes but checks and balances help to ensure that the process is optimal. Expertise can develop over time through reflection on the process.

This study explores the decision making process in a Targeted Mental Health in Schools Team (TaMHS) in one Local Authority. TaMHS is a three year Department for Children, Schools and Families’ pathfinder programme aiming ‘to improve mental health outcomes for children and young people via interventions delivered through school’ (DCSF, 2008d). Substantial changes have taken place within children’s services over recent years and research has explored the facilitators of and barriers to effective multi-agency working. However lack of clarity in terminology and detail has prevented an evaluation of the causal links between the facilitators and better outcomes for children and young people.

I have used a case study approach with a multi-agency team which has practitioners from six professional backgrounds. Interview data from the manager and six practitioners and an observation of one of their cluster meetings has been collected and analysed using thematic analysis.

I have developed a rich picture of the decision making process (DMP) in this team. The DMP is a complex, iterative process which is facilitated by a predetermined organisational structure and continues throughout the assessment and intervention stages. Diversity of views is welcomed and different perspectives are merged leading to shared decisions. Families and school staff are fully involved. Practitioners seem to use processes below conscious awareness as well as a more explicit process which links explanatory models, chiefly risk and resilience, with the choices of interventions. I have identified that many of the known facilitators for effective multi-agency working exist within this team and I propose that these could be the mechanisms which trigger effective decision making. I suggest that the group process involved in this team could be useful for other teams in children’s services. I also discuss ways to improve decision making and I have created a DMP Attributes Model which I have described and then discussed as a tool to aid professional development through the supervision process for practitioners within children’s services. I explore a possible role for educational psychologists in this process. Future research could study the usefulness of this tool with practitioners.
DECLARATION
No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.
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ACKNOWLEDGEMENTS

I would like to thank the whole of the Emotional Wellbeing in Schools Team and especially those members of the team who gave their time, reflections and ideas so generously in our interviews. Thank you to the team manager, who supported this research and who, at a very difficult time in the development of the service, helped me to further refine my ideas. Thank you to the senior managers within the department who gave permission for this research to take place.

I could not have managed this journey without the support and guidance of my supervisor, Dr Garry Squires. He made me believe that I could bring this to completion and helped me dig deeper and explore further. I would also like to thank the other course tutors and my fellow students, especially Debbie Shannon, who helped to make the last five years an enjoyable, interesting, learning experience.

Finally thank you to Tom and Rob who have been supportive and positive and to John for the meals, encouragement and the painstaking proofreading.
**ABBREVIATIONS**

<table>
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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>BEST</td>
<td>Behaviour and Education Support Team</td>
</tr>
<tr>
<td>BEACH</td>
<td>Bxxxxxx Early Action for Change</td>
</tr>
<tr>
<td>BHLP</td>
<td>Budget Holding Lead Professional</td>
</tr>
<tr>
<td>CAF</td>
<td>Common Assessment Framework</td>
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<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>COMOIRA</td>
<td>The Constructionist Model of Informed and Reasoned Action</td>
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<tr>
<td>DCSF</td>
<td>Department for Children Schools and Families</td>
</tr>
<tr>
<td>DfEE</td>
<td>Department for Education and Employment</td>
</tr>
<tr>
<td>DfES</td>
<td>Department for Education and Skills</td>
</tr>
<tr>
<td>DfE</td>
<td>Department for Education</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>DMP</td>
<td>Decision Making Process</td>
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<tr>
<td>ECM</td>
<td>Every Child Matters</td>
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<tr>
<td>EP</td>
<td>Educational Psychology/Educational Psychologist</td>
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<tr>
<td>EWIST</td>
<td>Emotional Wellbeing in Schools Team</td>
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<tr>
<td>IST</td>
<td>Inclusion Support Team</td>
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<tr>
<td>ICD-10</td>
<td>International Classification of Diseases</td>
</tr>
<tr>
<td>LA</td>
<td>Local Authority</td>
</tr>
<tr>
<td>SDQ</td>
<td>Strengths and Difficulties Questionnaire</td>
</tr>
<tr>
<td>SEAL</td>
<td>Social and Emotional Aspects of Learning</td>
</tr>
<tr>
<td>SENCo</td>
<td>Special Educational Needs Co-ordinator</td>
</tr>
<tr>
<td>SF</td>
<td>Solution Focused</td>
</tr>
<tr>
<td>SJT</td>
<td>Social Judgement Theory</td>
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<tr>
<td>TAC</td>
<td>Team around the Child</td>
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<tr>
<td>TaMHS</td>
<td>Targeted Mental Health in School</td>
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<tr>
<td>RCT</td>
<td>Randomised Control Trial</td>
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1 I have withheld the name of the local authority here and in some references to maintain confidentiality.
## Glossary of Terms

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<td>Adolescent</td>
<td>I have used this term when it is used in the context of child and adolescent mental health and would usually refer to people aged over 11.</td>
</tr>
<tr>
<td>Children and young people</td>
<td>From birth to 16</td>
</tr>
<tr>
<td>Collaborative working/collaboration</td>
<td>Agencies working together in a wide variety of different ways to pursue a common goal while also pursuing their own organisational goals.*</td>
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<tr>
<td>Collaborative</td>
<td>Used in the context of a practitioner working with children, families and other practitioners implies an aim to have an equal relationship with shared decision making.</td>
</tr>
<tr>
<td>Discipline</td>
<td>The overarching academic background such as psychology, education, mental health, occupational health, social work of the practitioners.</td>
</tr>
<tr>
<td>Emotional Wellbeing</td>
<td>In the naming of the team at the centre of this research the term emotional wellbeing was used deliberately instead of mental health to avoid any negative implications from a term using the word mental. The term is used to talk about a child's functioning and good emotional wellbeing implies a child is coping well with life, has friends and is reasonably happy. It is a term which is used frequently but rarely defined in detail.</td>
</tr>
<tr>
<td>Interagency working</td>
<td>More than one agency working together in a planned and formal way.*</td>
</tr>
<tr>
<td>Integration</td>
<td>Agencies working together within a single, often new organisational structure.*</td>
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<tr>
<td>Intervention</td>
<td>This refers to a wide range of activities for or on behalf of the child including altering the method of behaviour management in the classroom, direct work with the child, a parenting programme or family support. This is a wide definition. There is a list of interventions in Appendix 8.</td>
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<tr>
<td>Joined-up</td>
<td>Deliberate and coordinated planning and working, takes account of different policies and varying agency practice and values. Reference can be to joined-up thinking, practice or policy development.*</td>
</tr>
<tr>
<td>Joint working</td>
<td>Professionals from more than one agency working directly together on a project.*</td>
</tr>
<tr>
<td>Mental Disorder</td>
<td>Defined by the ICD-10 implies a clinically recognisable set of symptoms or behaviour associated in most cases with considerable distress and substantial interference with personal functions.</td>
</tr>
<tr>
<td>Mental Health</td>
<td>There are a number of definitions of mental health, including: “Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.” (World Health Organisation)</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<td>-------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>Multi-agency/cross-agency working</td>
<td>More than one agency working together. A service is provided by agencies acting in concert and drawing on pooled resources or pooled budgets.*</td>
</tr>
<tr>
<td>Multi-professional/ multi-disciplinary working</td>
<td>Working together of staff of different professions, background and training.*</td>
</tr>
<tr>
<td>Networks</td>
<td>Informal contact and communication between individuals or agencies.*</td>
</tr>
<tr>
<td>Partnership</td>
<td>‘Two or more people or organisations working together towards a common aim’ (Leeds Health Action Zone 2002, cited in Townsley et al. 2004).*</td>
</tr>
<tr>
<td>Practitioner</td>
<td>Someone who is working with children and families. It is the noun I use when referring to all members of the team.</td>
</tr>
<tr>
<td>Profession</td>
<td>Used in a wide-ranging way to imply the background training, role and discipline of the practitioners.</td>
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*Source: Percy-Smith (2005) unless otherwise stated. From Robinson 2008*
**PREFACE**

**Graduate and post-graduate qualifications**

1976 B.A. Psychology class 2:1
1977 PGCE
1977 DipEd
1980 MAppSci Educational Psychology and Child Guidance
1998 DipCoun

**Summaries of previous research papers submitted in part fulfilment for this degree of Doctor of Educational Psychology**

EXPLORING THE LANGUAGE BARRIER BETWEEN PRACTITIONERS IN RELATION TO CHILD AND ADOLESCENT MENTAL HEALTH (2007)

Having a common language is seen as an essential component of effective multi-agency working. This study explores in more detail the labelling behaviour, causal attributions and preferred interventions around children’s mental health of practitioners from different professional backgrounds. A questionnaire was distributed to a variety of practitioners representing the three major professional areas – health, education and social care. An analysis of the 124 responses reveals a high level of agreement about labelling but a wide spread of causal attributions and interventions. There are some differences between groups but also differences within groups. The discussion considered the paradox that the medical model, which is considered by many as an inappropriate way of conceptualising children’s behaviour, also provides a way of gathering evidence of best practice. Finally a proposal was offered that the common assessment framework combined with a case formulation approach using the known risk and resilience factors associated with child mental health problems might provide a way of overcoming the language barrier.

CHILDREN AND BEREAVEMENT: WHEN AND HOW TO SUPPORT THEM: A LITERATURE REVIEW (2008)

The aim of this review is to critically analyse research literature about children and bereavement, with a view to understanding when and how best to support them. The limitations of grief research are highlighted. However recent research has started to identify what factors are important in determining more positive or less negative outcomes for children and these are placed in the context of a risk and resilience model. Support and interventions are described and their effectiveness is
reviewed. The importance of consulting with children about their views is emphasized. Educational psychologists are in an ideal position to help school staff to properly evaluate complex assessments to determine the most appropriate support.

TALKING ABOUT DEATH IN SCHOOLS: A THEMATIC ANALYSIS OF THE EXPERIENCE OF IMPLEMENTING SEAL (2009)
Talking to children about death is not easy. Previous research has shown that teachers find it very hard to raise the subject of death with children in schools, especially when there is a personal connection. However there is a strong movement advocating that the topic of death is included in some way in the primary curriculum. The national introduction of the Social and Emotional Aspects of Learning (SEAL) resources in English schools in 2004 has created a universally available curriculum dealing with loss and bereavement to all primary schools. This study is an exploration of the implementation of SEAL in one local authority. Data was collected from local authority and school personnel using written answers from within a group meeting, semi-structured interviews and a questionnaire, as well as papers from the early phase of implementation. In all, 45% of settings provided information and two local authority officers. The data was analysed using thematic analysis. Two overarching themes – “Implementing SEAL” and “Delivering the topic of loss and bereavement” - are discussed and interpreted in detail. Concern is expressed in relation to how well the SEAL resources have been implemented compared to best practice internationally, especially in relation to the training received by teachers and other staff. In contrast, recent developments suggest that a more considered approach is being taken now. The materials do appear to allay some of the fears expressed by teachers. The form of analysis is discussed and the author explores its quality and usefulness.
1. INTRODUCTION

1.1. My Journey

This journey started fourteen years ago in an attempt to understand the decision making processes involved in counselling and in educational psychology. I had trained as an educational psychologist in Scotland in 1979/80 having previously worked as a teacher in a primary school. The EP course had an element of therapeutic training in it. I worked in local authorities in Scotland and England. In 1994 I was working as an educational psychologist in a residential college with young adults (16-25) who had learning difficulties and whose behaviour challenged mainstream services. I was training as a person-centred counsellor to enhance my capacity to work with them. Many of these young people had experienced little success in conventional education and were very wary and suspicious of anyone who was there to help. My usual bag of tools did not work. I had to find inner resources to create the right circumstances for them to accept my presence and eventually my help. I was aware of the differences between an essentially scientific/practitioner approach which had been the main, but not only, paradigm in my educational psychology training versus the existential, humanist tradition of person-centred counselling. I started to read about decision making and the use of intuition in the therapeutic encounter.

Returning to local authority work in 1999 I continued some counselling work but decided to stop counselling as a separate profession and concentrate on being an educational psychologist. I use counselling skills with children, young people and adults in my work but I do not offer counselling per se. My interest in decision making and intuition continued, in particular in relation to being a member of, and now the co-ordinator of, the authority's critical incident response team. We intervene in schools at the beginning of incidents to help the senior management team of the school manage the incident. I am also responsible for the training of team members and head teachers. I have been fascinated by the way team members learn how to respond. My observations of others and introspection about my own learning process suggest that there are logical learning processes involved which benefit from a classroom based approach about incidents and how people react. Then there is a scenario approach which involves discussing and agreeing actions. And finally there is the social learning that takes place from observing more experienced practitioners responding. During incidents, which are quickly evolving, uncertain and complex, advice has to be given to the head teachers for them to make decisions. There are rarely obviously correct solutions and we have to adapt our advice to
each situation (and no two are ever identical) but also to how we believe the head teacher is likely to respond to advice from us.

This journey has drawn on my involvement in a number of multi-agency teams in my work in a North West local authority. Their work is complex, their practitioners and their ways of working needed to be understood, and I have been interested in my own ways of adapting to this. It has required me to understand my own processes better. I am conscious that I will often decide to say something not based on a rational process but through instinct. Sometimes it just seems like the correct thing to say. I have not in that moment thought I am saying this because the underlying model tells me it is the right thing to say. Decision making is not just a feature of all our day to day lives but it is central to the practice of educational psychology. When the opportunity came to embark on this doctorate I decided I wanted to try to understand decision making further.

Embarking on research at this level meant I had to start to articulate aspects of the underlying paradigms within the field of research in educational psychology as well as within the practice of educational psychology. Essentially educational psychology, as I had been taught, came from a predominantly positivist tradition and for the last 30 years the profession has been struggling to find new theoretical and applied frameworks which could be embraced by the profession as a whole (Kelly et al., 2008). In developing my approach for this research that I came to recognise that, although there are for all practical purposes fundamental laws governing the physical world, within the social world it is not as certain that there are laws common across all contexts waiting to be discovered. However as an educational psychologist working with children, parents and schools I am able to apply the knowledge and skills learnt from previous experiences and research successfully in new contexts. This therefore implies some underlying commonality shared across different social contexts. In the course of developing this research I have moved from an essentially positivist tradition to a more qualitative approach. In this thesis, I take this further in studying decision making by different multi-agency practitioners in children’s services.

1.2. Decision making in children’s services
Decision making as an educational psychologist occurs at a number of levels. For example in a planning meeting with a Special Educational Needs Co-ordinator
(SENCo) the EP is making decisions about what to ask to elicit useful information and to come to a shared decision about which children will be priorities. Before a piece of work around an individual child can even begin there may be decisions about what theoretical position to take. Decisions with the SENCo might include a referral to other agencies especially if there appears to be a high level of risk of significant harm and if social care is not already involved. The concerns about a child can include their learning, emotional wellbeing, social relationships and/or behaviour. The SENCo may ask if there is an underlying developmental condition affecting the child. Decision making for other practitioners in children’s services will follow a very similar pattern.

1.3. **Brief case description**

I am not describing an actual child and their family but all the features would be familiar to anyone working in children’s services in my local authority.

Mary is 8 years old. She is attending her fifth school. She has a history of speech and language difficulties. She is struggling to make progress with literacy and numeracy. She has problem with peer relationships and often complains of bullying and her attendance is erratic. She lives with her mum and 2 older siblings and a younger sibling. Mary and her younger sibling have a different father from the two older children. He no longer lives with the family and there is no contact. Domestic violence occurred in the past which was witnessed by the children. Their mother has a new partner. There is current concern about domestic violence and possible drug abuse in the family but there is no firm evidence.

There are a number of decisions which would need to be made by school staff and subsequently by any other practitioners they decided to involve. These decisions would include the level of risk of significant harm and whether or not to make a referral to social care, what to do about school attendance and how to support her learning and emotional needs in school. This might involve changes at the whole school level, class level, group work or individual level. It might also involve direct work with the family and individual work with Mary.

1.4. **Building on my first research paper**

In my first research paper I studied the language barriers to multi-agency working. Interestingly the forerunner to the team in this research had the most consistent use of language across team members, more so than practitioners from the same disciplines such as educational psychologists and teachers, even though the team was composed of practitioners from different disciplines. The topics of my next two
research papers were determined by local imperatives within the authority as I was leading on a loss and bereavement action plan. I returned to the area of multi-agency working for my thesis with the aim to explore decision making within this team.

1.5. Targeted Mental Health in Schools

Due to my responsibilities I built up a connection with the implementation of the national Targeted Mental Health in School (TaMHS) Project in this North West local authority. The TaMHS project arose from a perceived gap in lower level services for children at risk from mental health problems. The national aims of the programme are to:

- improve mental health outcomes for children and young people via interventions delivered through schools;
- test ‘effective’ models of effective early intervention work within school based settings, which have a clear impact on improving mental health outcomes for children and young people at risk of and experiencing mental health problems;
- integrate effective early intervention models as part of wider Local Authority and PCT systems of assessment, referral and intervention work within targeted support services and specialist Child and Adolescent Mental Health Services (CAMHS);
- understand what are the factors promoting the successful implementation of the effective models at a (sic) strategic and operational levels so that these lessons can be further rolled out;
- understand what are the barriers (structural, cultural, financial and professional) to the successful implementation of effective models of work in schools at strategic and operational levels.

(DCSF, 2008d)

In the project information there is a strong emphasis on ‘evidence based models of therapeutic and holistic early intervention mental health work with children and families’. (DCSF, 2008d) One of the earliest national documents to be published was guidance for head teachers and commissioners about evidence informed practice. TaMHS project information also insisted that the work should build on the Social Emotional Aspects of Learning (SEAL) model, which is based around the idea of three levels of intervention: Wave 1 is the universal level for all children based around emotional literacy lessons and other whole school activities. Wave 2 is group based approaches and Wave 3 is targeted work for those at risk of experiencing mental health problems to be delivered by more experienced workers.

The officers of the LA submitted a bid in December 2007 to be one of the 25 Phase 1 pathfinders and were successful.

The model to be adopted by (this NW LA) will include early detection of
mental health problems, signposting to a key worker, and where appropriate access to other services. The project will develop schools (sic)CAMHS teams to provide specialist CAMH support to participating schools. They will provide a direct therapeutic service to children, young people and their families via the schools. Therapies offered will include solution focused work, and will aim to improve existing referral mechanisms to multi-agency specialist CAMHS. (DCSF Press Release, 24 January 2008)

Three clusters of schools were proposed with one secondary school and four primary schools in each cluster. The schools were selected based on indices of deprivation, engagement in Healthy Schools (schools involved had either achieved the National Healthy School Standard or were about to submit), good integration of SEAL, number of CAMHS referrals, capacity to run a pilot and connectivity between the primary and secondary school. This LA bid was also predicated on the aim to reconfigure the delivery of Child and Adolescent Mental Health Services in the authority.

I was responsible for chairing the early operational group in 2008 during the initial development stages and I was involved with some of the early work developing the links between agencies. In 2009, well after I stopped this role, I asked the team manager if it would be useful for team development if I was to involve the team in my research. She was delighted to explore this possibility with me. I then started the process of deciding what aspect of decision making I could study and what method I would use. My thinking developed through a series of conversations with the team manager and through a search of the decision making literature.

1.6. Research Questions
The following research questions arose from the discussions with the team manager, my reading of decision making research, knowledge of my own way of working and observations of colleagues in the course of my work. I had some knowledge of the way the team had developed but not the details of their team processes as they had finally been agreed. This led to question 1 below. I knew the original thinking about theoretical models and the plans for training, however I did not know how this was being translated into practice in their understanding of children and I hoped to explore that with question 2. Question 3 developed from my reading within the decision making and choice making research literature. Taking a realist approach, which I will discuss further in Chapter 5, I will be looking for the mechanisms influencing decisions within this particular team but with the possibility
that I can uncover some mechanisms which are more widely relevant to decision making by children’s services practitioners in other contexts.

1. What is the process of decision making around the choice of intervention for individual children?
2. How do team members conceptualise the circumstances that children and families and schools experience and why do they use these conceptualisations?
3. Why do the team make particular choices of interventions and what influences the choice of interventions?

1.7. Structure of Thesis

This research is an in-depth study of decision making in one particular LA team working in children’s services. I have reviewed and then summarised the changing national policy context as it is relevant to the TaMHS project and in my case study information I have itemised the LA’s position in each development to provide a fuller picture of the context of this team. I then review the multi-agency working literature and include a summary of the facilitators and barriers to effective working. I include a description of the team in light of these factors which both provides a fuller picture of the team and I believe will be relevant in examining the decision making mechanisms of this team. In my decision making literature review I have covered a wide range of disciplines. Decision making has been studied in depth in other fields, such as economics and medicine, and there is much to learn from research in other social contexts. In addition the team at the centre of the study is a multi-disciplinary team and its members will have drawn on practice from a variety of traditions. The disadvantage of using a wide lens is that there is a torrent of information and therefore I have had to be selective. I have summarised the current thinking from decision making research in an historical context and then I have selected from relevant disciplines such as medicine, psychology, psychiatry and social work to review decision making in practice. Finally I place decision making in children’s services in the context of the knowledge required to make decisions. In the methodology chapter I describe the theoretical position and why I have taken it, followed by a description of the data collection and analysis processes. In the following chapters I describe and discuss the results for each of my three research questions in turn. In Chapter 10 I provide a summary account of my findings, discuss the contribution they make to knowledge and indicate their implications for
practice in children’s services. In Chapter 11 I offer a model for use in supervision and discuss this in the context of educational psychology practice in teams. In the final chapter I discuss the limitations of this research and I reflect on my research journey.
2. **CASE STUDY TEAM – CONTEXT**

2.1. **Policy Context**

When I started this piece of research a Labour government had been in power since 1997. Under Labour there had been two prime ministers and the equivalent of 6 secretaries of state, and the titles and responsibilities of the department with the remit for this arena changed three times. These changes involved structural reorganisation: for instance in the last alteration under the Labour government child social care moved from the Department of Health to the DCSF. Now as I finish this there is a coalition government, following the election in May 2010, and the name has reverted to the Department for Education (last used in 1995). There are new responsibilities for the Department and a new secretary of state.

The team at the centre of this research was formed as a result of policies and initiatives arising within the life of the Labour Government 1997 - 2010. These changes, as I will describe below, involved structural changes to organisations as well as changes to work practices such as assessment tools and case tools. The team has professionals from health, education and social care. The remit is children’s mental health. I have therefore reviewed policy development within the national agenda around children’s services and child and adolescent mental health. I shall briefly outline these developments to demonstrate the level of change directed from the centre. It is not inevitable that all policy initiatives from central government lead to changes in practice on the front line. People tend to do what they have always done (Morris, 2009). Also different versions of policy develop around the country (Humphrey et al., 2008; Davidson, 2008). However as can be seen in the case study description of this team (Chapter 6) many changes were implemented locally.

2.2. **Labour Government 1997 - 2010**

2.2.1. **Tackling Social Exclusion**

The Labour government when they came into power had had the explicit aim of reducing child poverty, raising standards of education and also improving children’s life chances (Brown, 1999). A range of policy documents aimed at supporting families and a raft of financial measures were produced (Halliday & Asthana, 2004) creating the backdrop for more specific developments (DfEE, 1998). There were schemes designed to improve working together both at the national level and the
local level including the Children’s Fund (DCSF, 2007b) and Sure Start (DCSF, 2008c).

Another key aim was to prevent problems from arising in the first place or reaching crisis level. In 2000 the “Framework for Assessment of Children in Need and their Families” (DH et al., 2000) was published which was designed to support the work already outlined in Quality Protects which and was part of the guidance to protect children from harm and also ensure that looked after children gained full access to universal services such as health and education. The intention was that, although social care should take the lead responsibility for assessments, all other statutory agencies would contribute both to the assessment and in providing services. There was a recognition that for services to work together there was a need for a common language and shared values. This assessment framework was an attempt to provide a common language based on shared values and evidence of what is best for children. Themes which emerge later can be seen here including the necessity for agencies to work together because no single agency can protect children and ensure their wellbeing on their own. In 2001 a new Special Educational Needs (SEN) Code of Practice was published with the aim to ensure that all children’s educational needs be identified early and support provided using a graduated response. Once again the themes are about agencies working together, intervening early and finding ways to increase parental participation. There would be better support for parents and from this the Think Family approach emerged (Cabinet Office, 2007).

2.2.2. Child and Adolescent Mental Health

The same themes can be seen within the child and adolescent mental health arena which the Labour government built on the concept of a child and adolescent health service based on four distinct tiers brought in during the previous conservative administration (Health Advisory Service, 1995). In this service delivery model Tier 1 staff would include staff in schools, social workers, family support workers and others who do not necessarily see themselves as having a role in dealing with mental health problems. It also reinforced the necessity for an understanding of each other’s language and beliefs about mental health. It suggested that the confusion arose from, ‘the lack of terminological clarity’ (p.15) and, ‘that different disciplines may label similar conditions in differing ways’ (p.17). In education in 1999 the National Healthy Schools Programmes, a joint initiative from the Department of
Health and the Department for Education and Employment, was launched and one of the aims was to develop whole school approaches to improving both physical health and emotional wellbeing (Davidson, 2008).

However two surveys conducted by the Office of National Statistics in 1999 and 2004 in Great Britain identified that the prevalence of mental health problems in children and young people was gradually rising (Green et al., 2005; Meltzer et al., 2000). This led to increasing concern. Further central guidance in 2001, 2002 and the National Service Framework for Children, Young People and Maternity in 2004 were issued to try to raise standards of practice, including in the delivery of services around mental health and psychological wellbeing of children and young people (DfES & DH, 2004). Another programme with relevance to this area and the team under study is the introduction in 2005 of the Social and Emotional Aspects of Learning (SEAL) programme into primary schools (DfES, 2005). This was in line with the view of the importance of whole school involvement in the prevention of mental health difficulties (Hallam et al., 2005; Hallam et al., 2006).

In 2007 a number of parenting initiatives were introduced including the appointment of parenting practitioners in selected areas with the remit to be trained and train others in evidence based parenting programmes and then deliver these in their local areas usually for targeted families. A DFES and Treasury review in 2007 identified a lack of capacity in lower level mental health support, and as one response to this, in 2008 the Targeted Mental Health in Schools initiative, which I have already described, was launched (Davidson, 2008).

The National CAMHS Review (Davidson, 2008) was tasked with reviewing progress since 2004. They conclude that progress has been made but that services are still not comprehensive enough. They make a number of recommendations including: ensuring that knowledge about child development and how to promote children’s wellbeing be made available to all practitioners and parents; that an assessment of a child’s needs will include an assessment of their emotional wellbeing; that there should be access to specialist services for all children who need them; that there should be training in evidence based approaches; and that there should be a national strategy.
2.3. **Every Child Matters**

In the wider arena of children’s series in 2003 the green paper Every Child Matters was published. One of the key features of the ECM agenda is to improve the effectiveness of practitioners from different agencies working together. This programme developed out of the findings of the inquiry into Victoria Climbié’s death. In his speech on the presentation of the final report of the Inquiry Lord Laming (2003) says:

\[
\text{I am in no doubt that effective support for children and families cannot be achieved by a single agency acting alone. It depends on a number of agencies working well together. It is a multi-disciplinary task. (Laming 2003: p. 6)}
\]

As Lord Laming made clear the need for agencies to work together more effectively is not new, what is new is the extent to which it was now enshrined in the *Children Act 2004* and the *Education Act 2006*. These introduced duties on agencies to cooperate to safeguard the welfare of children. However these changes are not just about trying to prevent deaths but also to try and improve outcomes for all children. Much of the rhetoric was around prevention and early intervention (Walker et al., 2009). The document *Every Child Matters: Change for Children* (DfES, 2004), a cross governmental document, laid out the change programme. The Labour Government chose to prescribe change and reorganisation at all levels in children’s services. The changes proposed were linked closely to the known barriers to effective multi-agency working. Figure 1, referred to as the onion, demonstrates that the changes were to take place at all levels. This was to be a national framework for all changes within the 150 local change programmes.

![Figure 1: The Onion (ECM)](image-url)
2.4. Structural Change

The prescribed changes were extensive and included structural changes to local authorities as well as changes in tools and processes. Structural changes included co-location of services building on the Sure Start Programme (DfES, 2004) and using schools and other educational settings to provide good quality universal education, identifying problems early and then hosting specialist services which would be readily accessible because they would be provided on the same premises (DCSF, 2007a, 2008a). It also included the requirements placed on LAs and other agencies such as joint plans and the formation of a Children’s Trust in each area (DfES, 2004).

2.4.1. Does structural reorganisation achieve better outcomes for children?

Lord Laming talks about different agencies working well together. One question arising from this is what does working well together actually look like? Many terms are used to describe agencies working together such as integrated services, partnerships, collaborative partnerships, inter-agency working and joined up working resulting in ‘a terminological quagmire’ (Shucksmith et al., 2005: p. 85) The Labour government in their Every Child Matters response to The Climbie Inquiry took the view that integration of services was necessary. It is generally agreed that the terminology is confused and that this is a barrier to effectively measuring when integration has been achieved and if it is effective in improving outcomes for children and young people (Atkinson et al., 2002; Brown & White, 2006; Hamill & Boyd, 2001; Robinson et al., 2008; Sloper, 2004). I agree with Lord Laming that effective support for children and even simply providing universal services to help all children achieve the five ECM outcomes requires different services to work together. If we consider complex situations such as child protection, disability and mental health then it is clear agencies have to work together (Rothi & Leavey, 2006; Williams & Salmon, 2002). Williams & Salmon (2002) argue that this is essential as the causes of, for example, problems with mental health are multi-factorial and the solutions do not fit neatly into education, social or health services. Furthermore they argue no single discipline can possibly contain all the knowledge and skills required.

How to achieve the most effective form of working together is still in dispute. There are a number of reviews of the literature and they use different ways of defining terms and organising their conclusions. Some use the concept of models (Atkinson et al., 2002; Pettitt, 2003; Sloper, 2004); some refer to different levels (Axford &
Little, 2004; Morton, 2004; Williams & Salmon, 2002); and others the idea of a continuum (Brown & White, 2006; Frost, 2005). At one end of the continuum agencies work autonomously within their own boundaries and at the other end there is full integration. Somewhere in the middle is co-ordination between agencies. In their review Robinson et al., (2008) organise their findings of models and theories of integrated working under the following thematic headings: the extent of the integration, the integration of structures, the integration of processes and the reach of the integration. They agree integration has to be multi-layered.

Searching through the literature to try to find evidence of the impact of joined up working on the outcomes for children is like the search for the fabled chimera, because the terminological confusion makes it almost impossible to measure like with like, and also because of the way data is gathered (Sloper, 2004). Brown & White (2006) state:

Inquires (sic) into child protection cases have underlined what can happen when services fail to work in an integrated manner. It is assumed therefore that when services work better together, providing integrated services to children and their families that better outcomes should be achieved. However there is a lack of evidence to confirm such thinking, compounded by a difficulty in reliably measuring such outcomes. It is also assumed that such a way of working will result in economic efficiencies but again there is a lack of evidence to currently support this. (p 2)

Atkinson et al., (2002), Pettitt (2003) and Sloper (2004) all found little evidence for the effectiveness of multi-agency working itself on outcomes for children and young people. Axford & Little (2004:p.97) report that: ‘very few refocusing initiatives have been evaluated robustly with good data on outcomes for children’. Even when standardised measures are used it is difficult to disentangle if an outcome is related to a particular form of service delivery (Hallam et al., 2005; Webb & Vulliamy, 2004). Shucksmith et al., (2005) discuss the difficulty of measuring outcomes from one intervention in these types of studies. They argue that providing a simple intervention just because it is easier to measure is pointless. Complex environments require complex solutions which are hard to measure and costly evaluations are often overtaken by political changes. However they think a variety of models is better than if everyone had to work to a template – this is in real contrast to the ECM Change for Children (CfC) programme which is so prescriptive. O’Brien et al., (2009) suggest that with so many changes taking place across children's services
all at once it is very difficult to disentangle causal mechanisms within such a complex system.

In contrast to agencies becoming one service Abbott et al. (1995) describe an integrated service for children with mental health needs in the United States of America. The practitioners remained in their own agencies with agreed definitions of the needs for their target population, agreed outcomes and agreed funding. They report success based on improved outcomes for the children. Their processes involved service level agreements which were challenged and had to be renegotiated and staff who did not fit into the integrated service needing to be moved on through combined actions. Williams and Salmon (2002) conclude that there should be functional not structural reorganisation. The organisations should provide the right circumstances for collaboration and then practitioners should work together with the child and their parents.

Three national evaluations of strands of the ECM agenda Brandon et al. (2006a and 2006b), Audit Commission (2008) and Lord et al. (2008) all report that respondents say that it is too early to measure any impact on outcomes for children and young people. Furthermore two further national evaluations of strands of the ECM agenda (Lord et al., 2008; O’Brien et al., 2009; Walker et al., 2009) all express strong doubts that there is evidence to support the proposition that structural reorganisation leads to better outcomes. Both Frost (2005) and Hughes (2006) strongly challenge the assumption that organisational restructuring is necessary or even desirable to achieve better outcomes for children and young people. They both quote research carried out in the United States of America by Glisson & Hemmelgarn (1998), which unusually is a quasi-experimental, longitudinal study and which links organisational climate as opposed to organisational change with better outcomes for children. Positive organisational climate is described by the researchers as low levels of conflict, high levels of co-operation, the existence of role clarity, and staff being able to exercise personal discretion (Glisson & Hemmelgarn, 1998, Glisson & James, 2002).
2.4.2. Conclusion

The evidence that structural changes to services are essential for improved outcomes for children and young people is not there. There is general agreement with Lord Laming that to deliver effective support to children and families requires more than one agency or discipline. Practitioners must work with others not in the same agency or from the same discipline; however the shape that has to take is not clear except that outcomes for children and young people are better if individual agencies have positive organisational climates.

2.5. Facilitators and Barriers

Although the literature has not been able to produce clear evidence of improved outcomes for children and young people linked to a particular type of joined up working, there have been literature reviews (Atkinson et al., 2002; Pettitt, 2003; Robinson et al., 2008; Sloper, 2004) and studies including evaluations of initiatives (Brandon et al., 2006a, 2006b; Frost, 2005; Gannon-Leary et al., 2006; Glisson & Hemmelgarn, 1998; Glisson & James, 2002; Hamill & Boyd, 2001; Horwath & Morrison, 2007; Hughes, 2006; Hymans, 2006; Lord et al., 2008; Watson, 2006; Webb & Vulliamy, 2004) which have examined facilitators of and barriers to effective multi-agency/multi-disciplinary working. There are clear consistencies across the research and in some examples the facilitators are ways of overcoming identified barriers. In a mentoring conversation between David Cottrell (Professor of Psychiatry) and Paul Bollom (Multi-agency team manager) Cottrell comments that:

Interestingly in asking this question you used the term ‘multidisciplinary’. In our research we started from a position of wanting to explore multi-agency teams. However, the teams we researched all had members of different disciplines from one agency as well as staff from other agencies. We found that many, if not all, of the issues that arose in relation to different agency backgrounds applied just as well to those professionals employed by the same agency but from different disciplines. (Cottrell and Bollom, 2007: p.57)

The following are recognised facilitators: joint purpose or aims (Frost, 2005; Robinson et al., 2008; Sloper, 2004; Watson, 2006); joint funding streams ((Sloper, 2004); joint training (Frost, 2005; Hymans, 2006; Lord et al., 2008; Watson, 2006); clarity about roles and responsibilities within teams (Atkinson et al., 2002; Frost, 2005; Hamill & Boyd, 2001; Lord et al., 2008; Sloper, 2004); shared assessment tools (Atkinson et al., 2002; Sloper, 2004); shared IT systems (Gannon-Leary et al., 2006); commitment at all levels and strong leadership (Atkinson et al., 2002;
Robinson et al., 2008; Sloper, 2004) and clear joint strategy shared by all partners (Hymans, 2006; Watson, 2006). Although co-location is not an automatic solution to problems with multidisciplinary work (Malin & Morrow, 2007; Morrow et al., 2005) or in fact a necessary solution (Wenger, 1998) it can provide an opportunity for sharing information and improving understanding (Frost, 2005).

In addition to the features above a number of studies have identified the importance of practitioners who can work across boundaries, professionals who know and understand other agencies (Atkinson et al., 2002; Callaghan et al., 2003; Lippell & Jones, 2008; Robinson et al., 2008; Spratt et al., 2006). They can provide a bridge between team members and other services (Callaghan et al., 2003) and between families and other services (Brandon et al., 2006a; OPM, 2006). Within meetings educational psychologists have been identified as skilful in this role (Annan, 2005; Annan et al., 2008; Lippell & Jones, 2008). People with these skills are important at the strategic level as well called variously boundary spanner or reticulists (from networks) (Chandler et al., 2006; Easen et al., 2000; Williams, 2002a).

As I stated above many of these facilitators are attempts to overcome recognised barriers which are seen as inevitable when bringing people from different disciplines together in teams. Many studies refer to the barriers caused by culture clashes between professionals from different backgrounds, for example between social work and school staff (Webb & Vuliamy, 2004); between primary mental health workers placed in youth offending teams (Callaghan et al., 2003); between school staff and a range of other professionals (Hamill & Boyd, 2001; Shucksmith et al., 2005); between teachers and primary mental health workers (Rothi & Leavey, 2006) and between a range of professionals in a Sure Start (Malin & Morrow, 2007; Morrow et al., 2005). The mechanisms behind these clashes are often explained by different views on information sharing (Malin & Morrow, 2007; Morrow et al., 2005); the lack of a common language (Salmon, 2004; Salmon & Faris, 2006; Salmon & Rapport, 2005) and between different models of understanding (Frost & Robinson, 2007; Frost et al., 2005; Robinson & Cottrell, 2005). In an attempt to overcome the problem with language differences the DfES produced a glossary but the best way of understanding each other is to spend time developing an understanding (Frost, 2005; Lord et al., 2008). In fact difference or diversity of view is both inevitable and to be welcomed.
A multidisciplinary team without differences is a contradiction in terms. The point of a team is to bring together the different skills which a patient or client needs, and to combine them in a way which is not possible outside a team. If a team does not organise to combine different perspectives and efforts, then there is no point going to the expense of having a team. To make the most of these differences, a team must have agreed decision-making procedures. (Ovretveit, 1995: p.41)

Frost (2005) uses Wenger’s concept of communities of practice as the lens through which to review the literature and in particular findings from the Multi-Agency Team Work in Services for Children (Multi-Agency Team Work in Services for Children) research project under the headings mutual engagement, joint enterprise and shared repertoire.

Thus joined-up working does not necessarily mean doing away with difference. It seems then that models matter – professional beliefs exist in people’s heads and affect what they actually do. Living with different models is complex; it leads to conflict and change. (Frost, 2005: p. 39)

In an interesting contrast to this view Davidson (2008) discusses the problems with diversity of views and recommends applying a model which in her opinion would allow a joint approach. I think she underestimates the work it takes to reach an understanding between different disciplines. There are other mechanisms in operation in teams such as the issue of inequality in teams and the feelings of a power imbalance (Morrow et al., 2005; Frost, 2005, Malin & Morrow, 2007). Rather than insisting on one model it is important to develop an environment in which all views are valued and expertise is appreciated (Hamill & Boyd, 2001; Frost, 2005)

A positive organisational climate including low levels of conflict, high levels of co-operation, the existence of role clarity and staff being able to exercise personal discretion provides the foundation of an effective working environment (Brandon et al., 2006b; Glisson & Hemmelgarn, 1998; Glisson & James, 2002). Conversely Horwath & Morrison (2007) identify that a turbulent, poorly led and resourced agency is a barrier to effective joint working.

2.6. Implementing Every Child Matters

As described above the Every Child Matters change programme (DfES, 2004) was very prescriptive about both structural changes and also proposed national tools such as the common assessment framework (CAF), lead professionals and ContactPoint – a national database of all children in England. The common
processes were to exist against a backdrop of a shared language and understanding across the whole workforce. The CAF was developed from the Framework of Assessment (DH, 2000), following the same underlying principles and values. The same model of assessment with the child seen as part of a system was utilised with an extended element on the educational context (Gilligan & Manby, 2008). In addition to the intended national database with it’s strictly limited information each higher tier authority was required to introduce an Integrated Children’s System - a prescribed electronic case management system for social workers. This was also meant to improve data sharing (DCSF, 2008b). The concept of lead professional was introduced with the CAF to provide families with one point of contact and someone who ensures that the actions of the CAF would be completed. In 2006 there was a funding stream for selected LAs to introduce the concept of the Budget Holding Lead Professional (BHLP). The aim was to allow a lead professional working with children with additional needs to hold a budget and commission services (OPM, 2006; Walker et al., 2009).

Problems in implementing many of these changes were experienced, for example the CAF and Lead Professional (Brandon et al., 2006a, 2006b; Walker et al., 2009); the Integrated Children’s Systems (Munro, 2011b); Contact Point (Lord et al., 2008) and Children’s Trusts (Audit Commission, 2008) leading to concerns about a lack of coherence nationally and lack a knowledge about effectiveness.

2.7. Coalition Government 2010 onwards: Where are we now?

Trying to put together a coherent view now of what is happening and likely to happen concerning national policy and its impact on local development illustrates the point above concerning the lack of coherence as new ideas develop nationally. This is made even more complicated as this government has as one of its major policy planks that each local area should develop according to local needs and local people’s views. The coalition government want a ‘radical shift of responsibility and accountability away from the centre’ and ‘a programme of reform to devolve power and information to local areas’ (DfE Press Release, 3rd November 2010).

One of the first actions of the coalition Government was to cancel ContactPoint, the proposed integrated database. In light of the concerns expressed by Lord Laming in relation to Victoria Climbié and the fact that information was not shared between
LAs, it will be interesting to see what happens. In their press release the coalition government argues that

‘.all evidence and experience suggest stronger partnerships, greater integration of services and a shared purpose for all those working with and for children and families lead to better services for children, young people and families.’ ((DfE Press Release, 3rd November 2010)

However they are actively resisting the concept of centrally prescribed targets while still supporting, albeit in a very hands-off way, the five outcomes (Higgs, 2011). They go on to say they are going to reduce the level of central prescription. If the move is away from central prescription local areas are going to need to decide for themselves how to improve working together. They have decided there is no need for a single plan (DfE, 2011). The duty to have a Children’s Trust has been lifted. In some areas the Children’s Trusts are changing into Health and Wellbeing Boards. The budget cuts mean that in some areas the Directors of Children’s Services are acquiring new responsibilities. Local Safeguarding Boards with independent chairs are to remain in every area.

The indications from press reports are that integrated teams are being disbanded as the budget cuts bite (Butler, 2011). The Common Assessment Framework exists in paper form but not online, and where it is used by local areas it may well continue to be used, but no more development is to take place. In relation to the lead professional concept the coalition government is trialling a single point of contact for families in some areas (Higgs, 2011). Higgs (2011) concludes that the founding values of ECM may continue but that the structural changes are in doubt.

There are strands of work starting to emerge from the coalition government which point to future policy developments in the area of services for children and young people. There are indications that the coalition government is recognising the complexity of work in this arena. In February 2010, the then Shadow Children’s Minister Tim Loughton, in a speech to the Victoria Climbié Foundation, indicated the Tory Party view about the changes which had taken place over the last few years:

*If we concentrate too intensely on structural solutions..... we will not get very far. The people who rely most on social work are complex human beings whose needs confound the most complex of check-box forms. To help them we need the most competent of human beings who have the freedom and capacity to exercise professional judgement.* (Loughton 2010: p. 5)
In June 2010 Professor Eileen Munro was asked by the Secretary of State for Education to conduct an independent review of child protection in England explicitly because in his and her view the previous reforms had not led to the expected improvement in frontline practice (Munro, 2011a). I discuss the results of her review in more detail in the chapter on decision making in section 3.11.

The main underlying strands which seem to underpin the developing policy emerging from the coalition government are localism, the involvement of the Third Sector or Big Society and the centrality of parental control (DfE, 2011a). The changes being considered and encouraged mean of course a further period of instability and inconsistency as new practice is developed and embedded.

2.8. Conclusion

There are clear facilitators and barriers to effective multi-agency and multi-disciplinary working. Structural change does not appear to be a necessary condition. Working together effectively is not a product, it is a process, and it seems to take time to become effective. The team in this study were formed and operated against the background of widespread changes in local authority structures and responsibilities. In addition there was an implementation of national tools for assessment and the attempted implementation of national tools for information sharing. The team within this LA were at the forefront of these changes. As I write this the team in the format I describe has been disbanded and reformed into a totally new structure. This process has happened within a time span of less than four years. There are real issues both for people working within these systems given this amount of change and for the proper evaluation of service delivery. I discuss the implications of this further in Chapters 6 and 10.
3. **Decision Making Models and Frameworks**

Decision making is an area that has been extensively studied. The literature spans many disciplines including psychology, economics, medicine, sociology, pedagogy and many different settings ranging from decisions about which hedge fund to invest money in, the meaning of the blip on a radar screen and what action to take, which type of car to buy, what treatment to administer, whether or not to take a child into care or healthy living choices (Klein, 2008, 2009; Montgomery, 2006; Munro, 2011a, 2011b; Thaler & Sunstein, 2009). Decision making has been investigated in both laboratories and real life environments. Making decisions is an essential part of our existence. In this chapter I shall review the literature about decision making and briefly cover the main theoretical positions.

3.1. **Rational Decision Making**

Theories about making decisions have been proposed and models of optimal decision making have been described as far back as the ancient Greeks (Gracia, 2003; Montgomery, 2006). For Aristotle: ‘to be human is to reason – more particularly, to employ practical reason in thinking how to live’ (Grayling, 2003: p32). In Aristotle’s view reason governed the non-rational desires which all humans have. The concepts of rational decision making and making the optimal decision have been fundamental to research until relatively recently. The classical decision making model was once the main driving force for research (Lipshitz et al., 2001).

3.2. **Bounded Rationality**

Doubts about the centrality of rational decision making were raised and studied further by Herbert Simon. He started by studying decision making within business administration and is one of two psychologists who have received a Nobel Prize for economics with their research into decision making. Simon developed the notion of bounded rationality (Simon, 1986, 1991, 2000). He did not take credit for creating this idea but he significantly mapped out the factors that impact on pure rational choices, and he developed a stepped information processing model of rational decision making. Simon identified that people or organisations were always constrained: by their inability to be clear about all the possible choices in any situation, by the knowledge they have about the world, by their own cognitive processes such as memory capacity and the uncertainty of knowing how others will react.
3.3. Heuristics and Biases

Another development in decision making research was the finding that people use heuristics to make decisions. A heuristic is a process, a rule of thumb, which helps in making decisions but which can lead to biases. In their seminal paper in 1974, Amos Tversky and Daniel Kahneman described three heuristics and their accompanying biases used when making judgements in situations involving rapid decisions under pressure. Behavioural decision theory has been developed from this view.

The representativeness heuristic is the tendency of people to make judgements about something, such as an object, or a diagnosis of an illness, based on how much it looks like their prototype of the object or illness, not based on a statistical analysis of likelihood of its occurrence (Croskerry, 2009; Groopman, 2008; Kahneman & Frederick, 2002). There is general agreement that these heuristics have their usefulness in a rapid assessment of a situation. If, for example, our ancestors waited to decide if a movement in the undergrowth was or was not a tiger before taking some action they might not have had a second chance to make a leisurely assessment of the statistical likelihood of a tiger at that time and place.

Tversky & Kahneman (1974) also described the availability heuristic and the anchoring heuristic. The availability heuristic is the tendency to base a judgment on the likelihood of an event by how easy it is to think of an example. This can lead to the bias of assuming, incorrectly, that an event is much more likely to happen than in fact it is based on the vividness of the reporting of it, such as deaths through plane crashes compared to deaths through car crashes. The anchoring heuristic is the tendency to anchor a judgement to the first piece of information given. Many more heuristics and their associated biases have been hypothesised and discussed within the context of medical diagnostic errors (Croskerry, 2003, 2009; Norman & Eva, 2010) and within the practice of clinical psychologists (Garb, 2005). However it must be remembered that these heuristics have their uses and although biases can occur the process is still an adaptive, helpful process.
3.4. Naturalistic Decision Making

In the 1980s a new type of research developed to try to understand how people make decisions in real life settings rather than the controlled laboratory environment. Naturalistic decision making arose as a field of study in essence because of the failure of humans to make decisions in the rational way as predicted by the classical decision making model.

The heuristics and biases paradigm (e.g., Kahneman, Slovic, & Tversky, 1982) demonstrated that people did not adhere to the principles of optimal performance; respondents relied on heuristics as opposed to algorithmic strategies even when these strategies generated systematic deviations from optimal judgments as defined by the laws of probability, the axioms of expected utility theory, and Bayesian statistics. (Klein, 2008: p 456)

Klein (2008) discusses the development of this area of research which has resulted in several different models. He describes the various stages of the method, which usually starts with field studies to find out how people make decisions under difficult circumstance in which they have ‘limited time, uncertainty, high stakes, vague goals and unstable conditions.’ (p. 456). The types of teams have included the fire service and the military. One method used is to ask experienced people to describe what happened in an incident. The data is therefore retrospective, but the methods used would involve ways to confirm through observations and then simulations. In this model errors are not necessarily seen as evidence of a faulty process, as in the behavioural decision making. Instead it is suggested that errors can lead to learning and therefore someone can become more proficient in those situations. People can learn from their errors (Lipshitz et al., 2001). From this research the recognition-primed decision model is proposed to explain how people make successful decisions in very difficult circumstances. The model suggests that as people are involved in situations over time they learn patterns and when they need to make a decision quickly they match the situation to the patterns (Lipshitz et al., 2001).

3.5. Social Judgement Theory

Another example of studying decision making in a real world setting and based on a different methodological framework from Klein and colleagues is social judgement theory. Social judgement theory arose from Brunswik’s view that decisions and judgement should be studied through a methodology which is representative of the real world in which the process is going to take place, otherwise research results cannot be generalised beyond the laboratory. But by using statistical methods it is
possible to link cues in the environment to the judgements made using a conceptual model which he called the lens model.

‘It is possible to capture the implicit policy of judges by using multiple regression analysis to show which of the various cues predict their overall judgment.’ (Evans, 2008: p. 266)

Hammond developed these ideas further (Cooksey, 1996; Doherty & Kurz, 1996; Hammond, 1996). As Cooksey states, Hammond:

‘...fully accepted that the relationship between a decision maker or judge and the decision task environment (ecology) in which he or she was embedded was the fundamental cognitive focus for analysis.’ (p. 142)

Social judgement theory has been applied in studies of clinical reasoning. In Wigton’s (1996) view SJT is a useful model for studying medical judgement, because doctors’ judgements are made in uncertain circumstances with multiple cues. His review of the research literature argues that the studies have shown that doctors often do not make the decisions in the way they think they do. Mumpower & Stewart (1996) uses Social Judgement Theory as a way of understanding why experts in a field disagree with each other. Reilly (1996) uses SJT in a study of insight into one’s own and others’ judgements.

Harries & Harries (2001a) review the different research methodologies which have been used to study clinical reasoning in occupational therapists’ judgements. They outline the disadvantages in both ethnographic and in information processing studies. In neither type of study they argue is it possible to fully access the decision makers’ awareness of how information is being used to make judgements. They suggest that interviews which rely on retrospective accounts are unreliable due to memory issues. For example studies which require practitioners to think aloud as they read the information for a new referral, may access the working memory and the information they attend to but this information may not be the information which leads to the decision. However ethnographic studies of decision making in the real world can offer ideas for further study. In their second paper Harries & Harries (2001b) describe a study using judgement analysis, the methodology of social judgement theory, ‘to identify the policies that expert occupational therapists used in the prioritisation of occupational therapy referrals within the field of community mental health.’ (p. 285)
3.6. Dual Processing Theories

Theory development within decision making has moved on from the classical model which promoted the idea of the pure rational agent. In an article in 2008 Evans reviews dual processing theories within what he describes as: ‘higher’ cognitive processes ..... thinking, reasoning, decision-making and social judgement’ (p 256). In essence dual processing theories propose two systems, referred to as System 1 and System 2 by Kahneman & Frederick (2002). They define System 1 as Intuitive which is fast, automatic, and effortless but not available to conscious awareness compared with System 2 that they call Reflective which is slow, deductive, follows rules and is available to the individual. They also indicate that the two systems are likely to operate at different times in different types of situation. Evans (2008) concludes that this position is ‘oversimplified and misleading’ (p. 170). He suggests that it would be more useful to talk about Type 1 and Type 2 instead of using the word system as all theories contrast processes which are fast, automatic or unconscious with processes which are more slow, effortful and conscious but they might not be systems as such.

In contrast to the idea of separate systems or types Hammond (Evans 2008) proposes a cognitive continuum theory which contrasts intuitive and analytic thinking as two ends of a continuum rather than separate processes. SJT is one way to study the intuitive end of the continuum – the end not available to conscious awareness.

In decision making research one problem encountered frequently is the use of different terms to describe what seems like the same idea or concept, and in some cases different theories are actually very similar to each other (Fischhoff, 2010). In his review article Fischhoff describes the development of behavioural decision theory research which he points out has many disputes and disagreements but which in his opinion is an area which shows that theoretical and practical research can be mutually supportive. He concludes that it is an area where researchers and applied practitioners should work together to develop theory further.

3.7. Clinical Decision Making

The study of decision making by doctors and other medical professionals has a long history. I have not made a systematic search of the literature, instead I report here
some direct examples where the decision making theories reported above have been applied to clinical decision making. However firstly there is an ontological issue which Montgomery (2006) explores in her book “How Doctors Think”. She makes the distinction, in the same manner as Aristotle, between the practice of medicine and medical research designed to identify causes. Both she and Groopman (2008) explore the view that the practice of medicine is more an art than a science. There is recognition that clinical decision making is not best described by a rational decision model.

The dual process theory has been used to study diagnostic error (Croskerry, 2003, 2009; Norman, 2009; Norman & Eva, 2010). Norman (2009) lists possible biases which might influence diagnosis such as confirmation bias which involves only looking for data to confirm not refute a hypothesis. This is indicative, he suggests, of the process of satisficing: rushing to a conclusion without considering alternatives.

Sladek et al. (2006) recommend the dual process model of reasoning as a way of identifying factors which could be the basis of individual differences which could then explain the differential uptake of research findings influencing clinical decisions. Sladek et al. (2008) found that doctors’ self reported thinking styles on an experiential versus rational dimension were correlated with a more guideline discordant practice versus guideline concordant practice.

3.8. Decision making and emotions
Another factor which has reinforced the demise of a purely rational decision making model is the recognition of the role of emotions in decision making. Damasio and colleagues have identified that when damage occurs in particular regions of the brain this impacts on the ability of people to make decisions and also significantly on their processing of emotions (Bechara et al., 1994; Damasio et al., 1996). In essence we need emotions to help us to make decisions. This has led to the somatic marker hypothesis (Bechara et al., 2000). Researchers in neuroscience have started to map the areas of the brain involved with decision making (Croskerry, 2009). Bechara also names areas of the brain linked to decision making.
In “How We Make Decisions”, Montague (2007) summarises the current thinking within computational neuroscience about decision making. In this book aimed at a lay audience, he is describing research using an information processing theoretical underpinning but linking it directly to the actual systems within the brain. In a wide-ranging tour of many disciplines he offers an approach which attempts to connect outward behaviour to the inner workings of the human brain and links this to evolutionary biology. There is still a wide gap between ideas about the underlying brain structures, models of decision making and what actually happens in the real world in all its complexity. Evidence is being found suggesting that the theoretical position of different systems including something called intuition has some basis in brain systems. McCrea (2010) in a review describes two systems with their neural correlates – the C-system (ReflCtive) and the X-system (ReflXive). He argues that:

Hence, the functional neuroanatomy of the intuitive networks implies that the X-system is: (i) affective (ii) slow to form (iii) resistant to and slow to change (iv) insensitive to one’s thoughts about one’s own self and finally (v) insensitive to explicit declarative feedback from others. There is good evidence to suggest that the C-system is relied on only by default in novel decision making (such as novel insight problems), when heuristic automatic judgments based on associative and intuitive systems are unreliable. (p. 17)

3.9. Intuition

However Glockner & Witteman (2010) argue that the definition of intuition is not specific or shared enough between researchers. They identify four potentially different mechanisms and recommend that further research moves forward in each area. They conclude that there is common ground in the different constructions of intuition and common ground about the conditions in which good decisions will be made using “intuition” or System/Type 1 processes. The input has to be unbiased, representative and sufficient. There are difficulties in relying on intuition when information is biased, although conscious awareness can correct for bias or unrepresentative information. One suggestion is that sensory information being processed below conscious awareness can have an effect on physiological arousal and this signals to the brain that there is an inconsistency.

A number of other authors have referred to this type of unconscious process by other names for example ‘knowing in action’ (Schön, 2003: p. 241) and ‘tacit knowledge’ (Henry, 2010). Schön in his book “The Reflective Practitioner” explores
the work practices of professionals from a number of disciplines including town planning, architecture and psychotherapy. His argument is that decisions and problem solving within these occupations are too complex to allow a step by step approach and professionals need to apply reflection to their actions in order to check their decisions and to learn as they progress in their fields. Schön argues for limits to technical rationality not least because it is hard to describe how you know what you know. Bringing this to conscious awareness is not easy. The concept of tacit knowing is discussed in the context of medical doctors’ clinical decision making by Henry (2010). He argues that doctors need to think about what it is they know and how they know it. As Montgomery (2006) and Groopman (2008) both argue practising medicine is not a simple positivist reductionist process. There is an element of an unconscious process guiding the decisions they make and sometimes doctors do not know why one course of action seems better than another (Hall, 2002).

Welling (2005) discusses intuition in the context of psychotherapy and proposes a 5 phase model. Mistakenly he suggests that there is no cognitive model for intuition and very little research and does not refer to Kahneman or Klein. However he does illustrate the difficulty with definitions of intuition by listing 11 different meanings for intuition ranging from gut-feelings to a scientist knowing what to research next through to instant solutions appearing from nowhere.

The acknowledgement of the importance of intuition in clinical decision making has also been recognised in the field of nursing (Banning, 2008; Dowding, 2009; Easen & Wilcockson, 1996; Hardy & Smith, 2008) and in occupational therapy (Harries & Harries, 2001a and b).

3.10. Improving Decision Making
A theme which recurs in the literature is how to improve decision making amongst practitioners and also amongst the general public. The literature is clear that much decision making takes place in our unconscious and is therefore not available at the time or in retrospect to review and learn from in a conscious way. However learning does take place and the evidence is clear that people can become more expert the longer they are involved in specific areas and in environments which provide regular feedback (Herbig & Glockner, 2009; Klein, 2009; Schön, 2003). One way of
achieving this seems to be some form of reflection. I discuss this further below. There are discussions as well about how to improve clinical decision making through education and training. Hall (2002) discusses explicitly teaching medical students the research around heuristics and subsequent biases and linking this to clinical decision making. She suggests from her own experience that being taught that these biases can occur produces resistance to them.

Continuing the theme of medicine Gracia (2003) takes the view that, within the context of making ethical decisions in clinical medicine, a process of deliberation with someone else in a consultative role is necessary to make the best decision. He recognises the effect of emotions on decision making. For example he suggests that anxiety can prevent people from hearing the point of view of the other party. The answer in his view is to be as deliberate and consistent in the process as possible. In the end the person with the moral dilemma has the responsibility to decide their actions but they need someone else to help them master their own biases and inconsistencies hence the use of ethics committees to review or make decisions.

This issue of building up expertise through reflection on practice is explored in two studies about educational psychologists. Quicke (2000) uses a phenomenological approach to think and write about a one-off encounter with a child and Pomerantz (2008) uses Foucauldian Discourse Analysis to analyse a transcript of a conversation between an EP and three members of staff at a secondary school. Both papers take the view that the EP has to be clear about the stance they are taking – both are from a social constructivist viewpoint in which the belief is that knowledge is socially constructed in our encounters. They state that it is essential that EPs reflect on their work and on the effect they have during encounters in order to be more effective in their practice.

Another way of improving decision making, which is relevant to the task of making choices, seems to be by changing the environment around people in order to overcome biases (Kahneman & Frederick, 2002). Fischhoff (2010) summarises ways of removing or reducing the effects of bias on decision making. These have included for example asking people to generate ways in which their choice might be wrong to reduce over-confidence. Helping individuals to make better decisions has become a political agenda and some of this research is now potentially influencing
government policy around health choices (Thaler & Sunstein, 2009) and within the field of child protection.

3.11. Decision making and policy development - Child Protection

In the highly complex and high stakes arena of child protection there are developing views which acknowledge the inadequate nature of a purely rational decision making model. In his newspaper article in response to the Laming Inquiry report Ferguson (2003) makes the point that;

*The real weakness of this report is that, just like its predecessors, it tries to impose a rational analysis on practices and processes, which have an irrational character.*

Furthermore he argues:

*Good child protection work requires staff to hone a keen intuitive sense to pick up signs of abuse or neglect, and to regularly reflect on their suspicions. Strong management and accountability can indeed help, but ultimately only if the true complexities of practice are fully understood.*

Munro (2010, 2011a, 2011b) in her review of child protection practice for the coalition government chose to use a systems analysis as a first step. She had already completed a review of child abuse inquiries (Munro, 1999) and had concluded that the errors made were not random and that decision making research could illuminate the process. Some errors made were as a result of the decision makers using, for example, the representativeness heuristic and therefore oversimplifying inherently complex situations. She argued the starting point of any child death inquiry should be an acknowledgement that human error is inevitable and then to try to understand why errors are made rather than using the Inquiry approach to find someone to blame. She recommended systems change to ensure that social workers were supported to check their decisions. She argues very strongly that:

‘Practitioners must be held accountable when malpractice is proven but this is a matter for employer-led disciplinary processes and must not be confused with acknowledging the mistakes that inevitably arise because of the inherent uncertainty in the work. Children and young people will be safer if workers can revise assessments or change decisions because they develop a different understanding of the problems without fear of being criticised for not getting it right first time.’ (Munro 2010: p. 39 my highlights)
In the second part of her interim report Munro (2011a) explores the role of intuition in the decisions made by social workers. She criticises the increasing attempt in response to tragic criminal deaths of children of relying on a managerialist approach:

‘The managerialist approach has been called a ‘rational technical approach’, where the emphasis has been on the conscious, cognitive elements of the task of working with children and families, on collecting information, and making plans.’ (p. 36)

She further argues that:

‘Conscious logical thinking has quite rightly been highly valued as a human attribute, but the traditional view that it is inherently superior to intuition and emotion has been overturned by developments in neuropsychology.’ (p.37)

Munro (2011b) further discusses intuition in the third and final report. She argues that it is fundamental to good social work practice. She states that although not available to conscious awareness and possibly considered mystical ‘its physical location in the brain and the features of the process are understood.’ (p. 90).

3.12. Supervision

Munro (2011b) argues for checks and balances in the system as she recognises that intuition is not a reliable system on its own and unfortunately can give the person a sense of being certain about their decision. They need someone else to challenge them as discussed previously in section 3.10. Schön (2003) argues that people need to be reflective about their work. In his view this is by noticing over time what works best in what situation and building up expertise. However as we have already seen this is not a simple process in the context of decision making. There are a number of factors which impinge including the problem of retrospectively retrieving memory and the fact that some decision making is below the surface. In addition the practitioner has to learn how to access supervision in a way which helps them to learn. In one study the need for social workers to be assertive to access supervision effectively is raised (Broadhurst et al., 2010).

3.13. Decision making: complexity and wicked problems

One feature of the difference between decision making in the laboratory and in the real world is the level of complexity involved. In the laboratory and using the
experimental approach the aim is to control variables and reduce complexity as much as possible so that conclusions can be drawn based on measuring the effect of manipulating one or two variables. In the medical arena this would include randomised controlled trials to measure the efficacy of drugs. In the real world there are many factors which are co-dependent and interact in unpredictable ways. In education Bore & Wright (2009) use the term wicked to describe these types of problems. They contrast tame and wicked problems and suggest that policy developers and others often believe that problems are tame when in fact they are wicked. Wicked problems are ones which are not easily defined, have many causal levels and are not solved by using algorithmic, step by step approaches. Bore and Wright go so far as to suggest that the scientific method, meaning a simple linear approach, does not work with societal problems and are critical of policy makers who assume that the scientific method can answer the complex problems that are inevitable in these arenas such as in education. They quote David Blunkett a Labour Secretary of State for Education.

One of our prime needs is to be able to measure the size of the effect of A on B. This is genuine social science and reliable answers can only be reached if social scientists are willing to engage in this endeavour. We are not interested in worthless correlations based on small samples from which it is impossible to draw generalisable conclusions. (Blunkett 2000: p. 245)

In Chapter 4 I will discuss the scientific approach, including randomised controlled trials, in more detail.

Complexity has also been discussed in other fields. Schön (2003) discusses professionals working in fields such as engineering, psychotherapy and management:

‘...the complexity, uncertainty, instability, uniqueness and value conflict which are increasingly perceived as central to the world of professional practice.’ (p. 39)

Situations develop over time in unpredictable ways so a plan cannot be developed with any certainty, but when an action is decided on, it can have unforeseen consequences and the nature of the problem changing as actions are taken. Munro (2010) also discusses complexity in the world of child protection.
‘In its future work, the review will consider: the need for a practice and policy framework which acknowledges the complexity of the social work task, the emotional and intellectual demands on individuals and the central importance of critical reflection;’ (p.420)

There are no simple or even complicated solutions that can be applied with certainty with each new child protection case. Each child and each situation is unique and has to be approached as a complex situation.

In health care there are discussions of complexity and the use of the Complex Adaptive System Model (Plsek & Greenhalgh, 2001; Plsek & Wilson, 2001). They describe a complex adaptive system as one made up of a collection of individuals who can act independently of each other, unpredictably, and whose actions affect the context for everyone else; for example an ecosystem such as a pond, the financial market, a family or a team. The boundaries of the system are fuzzy so members of one system can be members of other systems and it is not clear where one system ends and another one begins. The behaviour of the members of the system is determined by internalised rules which are not necessarily available to the other members of the system. Systems are changing over time and influence each other because as one system changes so do other ones. An example of this is the changes taking place within local authorities due to budget cuts and the subsequent changes of teams within the LA. Some issues within complex systems are unsolvable and this creates tensions within the system. The interactions within a system lead to constant change and unpredictable consequences. The development of a system is non-linear and therefore harder to predict or manage. There can be patterns within the system which can be identified and in some instances there are attractor patterns in people’s behaviours which can be used to influence changes. There are also patterns of behaviour which emerge from complex systems which can be identified and which can lead to productive outcomes.

Also they conclude that it is important to identify those situations which respond best to simple solutions. An example of this could be the checklist solution recommended by Gawande (2010). He has tried and tested checklists in surgery situations which cover certain common errors made by surgery teams and which seek to avoid those errors in future. He developed his checklists after studying those used in the
aviation industry developed as a result of actual incidents, but if a new problem arises during a flight a pilot would have to create a new solution. However they argue that inherent within complex adaptive systems there are zones of complexity which cannot be treated as though there is a simple solution. Plsek & Greenhalgh (2001) suggest that it is better to try a number of approaches and then over time concentrate on those solutions which seem to be working best. This is very similar to the approach taken by Pawson & Tilley (2008) in their realistic evaluation approach.

Hall (2002) discusses intuition in medical decisions and describes three types of uncertainty within clinical decision making: technical, personal and conceptual. Technical uncertainty covers issues such as poorly researched statements. Personal uncertainty arises from issues such as the doctor/patient relationship and finally conceptual uncertainty covers such things as competing needs between patients e.g. who should receive a kidney transplant when there is a shortage. This analysis demonstrates in part that the answer to these uncertainties is not simply to provide more information.

Highly relevant to my research Williams (2002b) discusses complexity, uncertainty and decision-making in the arena of child and adolescent mental health services. He argues that Hall’s uncertainty analysis and Plsek and colleagues’ use of complex adaptive systems’ model are similar. He recommends that a combination of approaches is required to improve clinical decision making and cope with inherent high levels of complexity. These would include as described above using guidelines and algorithms when appropriate, applying evidence when available, involving patients in decisions, and training and education around biases for all.

3.14. Decision making with, not for, others
So far I have discussed decision making from the point of view of one practitioner making an independent decision on their own. However, as can be recognised in the discussion of complex issues above, decisions in the helping professions more usually these days involve the patient or client or child and their family more directly. I shall discuss this briefly in the context of medicine and then I shall look at educational psychology practice.
3.15. **Shared Decision Making**

In the medical world there is a concept of Shared Decision Making (Bell et al., 2007; Makoul & Clayman, 2006). Makoul and Clayman carried out systematic literature search to identify a shared conceptual definition. However they discovered that there was no shared definition of a model of shared decision making. Based on the most common features they identified in their search they then created a framework in which there are: essential elements, such as define the problem and discuss options, without which the model could not be called shared decision making; some ideal elements, such as define roles, which would enhance the process; and finally general qualities, such as involve two people and mutual respect, which provide an overall sense of the process but are harder to research. They conclude that ‘patients and providers have different – but equally valuable – perspectives and roles in the medical encounter.’ (p.307)

In contrast Bell et al. (2007) describe research based on the concept of a Model of Shared Decision Making in the mental health arena. In this case the participants are the doctors and the pharmacists. The information from the patient is conveyed to the meeting by the pharmacist. The aim is to agree treatment options. In this research the imbalance of power is demonstrated not just by the absence of the patient but also by the fact that the doctors always made the final decisions.

A research project has just been launched to study shared decision making in CAMHS (Hoffman, 2011). In their definition of shared decision making the child or young person is to be centrally involved in decisions from the first exploration of the problem and treatment choices through to the reviews of progress. They are provided with information about options in an age appropriate way. The intention is to discover if this leads to better outcomes for young people.

3.16. **Decision making: educational psychology and frameworks for practice**

Decision making within educational psychology does not appear, from my literature search, to be a concept which is studied in its own right. Instead the main concern of writers in the UK is the paradigm stance taken by practitioners. This is illustrated in two articles written by Stobie (2002a, 2002b). She describes the change in
perspective over the time period from 1948 – 1990s. She interviews educational psychologists who trained and worked within this era. In her results she describes a move from a more medical model, with the child as the patient, towards a systemic, collaborative, problem solving model. Although these models co-exist to some extent now, in her view, the greatest differences exist between the period before the 1970s and afterwards. The medical model in essence conforms to the notion that the practitioner is the expert, the assessment provides the information and the expert makes a decision about the “condition” and then recommends an appropriate intervention or action. The later paradigm emphasises the collaborative stance, decisions are made collectively and solutions are found together. In this context one can assume the practitioner is making decisions such as what to ask, how to effect change, what to say and what theoretical stance to adopt (Quicke, 2000). The paradigm drives the type of decision making. The frameworks described below all take the later stance.

Annan (2005) approaches the concept of decision making in educational psychology practice from the viewpoint of situational analysis. This she argues is what people have to do when they are in complex environments making decisions and she argues errors occur when people have not analysed the situation as well as they could. She believes that: ‘Situational analysis supports psychologists to render difficult situations more manageable through reduction of their complexity’ (p.32). She argues that by involving other people in analysing the situation then any bias or prejudice held by the educational psychologist or others will be reduced. The theoretical stance taken includes the view that knowledge and understanding are socially constructed and that children should be viewed as part of complex systems and not in isolation. She sees solutions as emerging from situations and she proposes that reflection and review are necessary. Although not directly referenced this bears a similarity to the ideas from complex adaptive system approaches. She also emphasises that educational psychologists need to build up their expertise over time through supervised, reflective practice. The step by step approach is cyclical, as are those described below, and build into the process an opportunity to reflect on practice but also to adapt interventions as a result of outcomes. This framework also builds in the use of evidence based interventions. I discuss this further in Chapter 10.
Kelly et al. (2008) have brought together a collection of writings about frameworks for practice in educational psychology in the UK. Their stated aim is:

_to allow trainee educational psychologists and practitioners to access the concepts behind emerging practice frameworks and to become familiar with their relative characteristics and usefulness._ (p. 15)

They are responding to their belief that in the literature there is a concentration on the process of change and the role confusion and ineffectiveness of contemporary practitioners. They want to concentrate on how to help practitioners apply theory in educational contexts. They not only have edited this collection but they are also responsible for one of the frameworks in this book. They define a framework as ‘a structure with a set of parts that sit or work together.’ (p. 18)

The three overarching frameworks included in this book describe a series of steps in a process in which decision making is one part. They all bring together theoretical models with practice steps. They all start off with the position that the type of situations educational psychologists are faced with in their practice are complex and will involve a number of other people both in terms of describing the situation and in taking action. The three executive frameworks have all been produced by trainers of educational psychology courses. The three are: the Monsen et al. Problem Solving Model (Monsen and Frederickson describe here adaptations to this model); The Constructionist Model of Informed and Reasoned Action (COMOIRA) and The Woolfson et al. Integrated Framework.

They all have steps in the process, they all talk about different viewpoints, and they all expect the educational psychologists to be clear about the theoretical underpinnings of their approach. Broadly they are from a social constructionist viewpoint. Monsen & Frederickson (2008) outline the underpinnings of their model and include information theory, Dewey’s model of reflective thinking, critical realism and an interactive factors framework as a way to map the problem which looks at biology, cognition (and affect), behaviour and the environment (eco-systemic approach such as Bronfenbrenner). Woolfson (2008) describes The Woolfson et al. Integrated Framework which was developed in the first place from the original Monsen et al. framework. Gameson (2008) describes the COMOIRA approach which is from a strong constructivist approach; they describe it as a heuristic rather than an algorithmic approach, which means that it is ‘flexible, iterative and a process...
of trial and error rather than a set of rules’ (p. 97). This comment seems to acknowledge decision making research more strongly than the other authors and they also argue that the framework allows for complexity as it can respond to changing situations. Throughout the framework there are decision points and the whole process concentrates on change.

In view of the decision making research which points to the development of expertise over time through reflection on practice, the concept of developing expertise within educational psychology practice is an interesting topic. Kelly (2006) conducted a small scale qualitative piece of research to identify if educational psychologists with experience of the Monsen et al. framework in their training found it useful as qualified EPs. She reports that there is evidence that the framework is still being used. They have all made adaptations to the model. The model provides the executive framework for decision making but they adapt it to fit their own psychological stance. She reports feedback from one respondent who asks if there is a framework to help with messy or wicked real world problems, as though this one does not. Kelly then directly refers to the expertise of the EP to deal with the complex nature of the context.

In his contribution to the frameworks book, Burden (2008) tackles this issue of complexity and challenges the assumption that educational psychology is a science rather than an art. This seems to have direct relevance to the discussions taking place within the medical world as described by Montgomery (2006).

In utilising the solution focused approach educational psychologists are explicitly taking the stance that their role is not as the expert who knows the answers but instead as enablers of decision making. In their study of the use of solution based approaches Stobie et al. (2005), using a questionnaire, ask about the use of Solution Focused approaches in educational psychology practice in the UK. This study does not identify if this approach is used by most or only by some educational psychologists. There is some evidence that it is used pragmatically in the sense that some of the tools can be used in the short amount of time available for each encounter. They identify that much of the input is not evaluated and therefore not based on evidence, which begs the question how EPs are developing expertise over time if they are not receiving systematic feedback about their practice.
3.17. Multi-professional decision making - making decisions in teams

My research is about a team of people working with children, families, schools and other agencies around problems which appear and are ongoing within several different environments and systems, e.g. family, school, communities. The team comes from different professional backgrounds and therefore it is important to also review decision making in teams, which is influenced by a number of factors. In team decision making it is important not just to understand the process from the point of the individual but also the effect of a group of people on an individual and on the process and the team itself. A group process adds another level of complexity to the situation. In Chapter 2 I reviewed the literature concerning multi-agency working in general and discussed a wider range of issues, but in this section I review decision making per se in multi-disciplinary teams. I have searched specifically for research studies about decision making which are within the area of multidisciplinary working with adults or children, involving two or more disciplines relating to the delivery of services such as social care, mental health but not specifically physical health needs.

3.17.1. Group factors

From research within social psychology there are factors which operate when groups of people come together in meetings. These include a tendency within groups to base decisions not on the information available but in order to achieve acceptance in the group; the polarisation of opinions such that the group makes more extreme decisions than an individual on their own; the development of group norms becoming of paramount importance so that conflict is avoided to ensure the group’s survival; and finally so-called group think which is a rush to consensus rather than considering all alternatives, especially if a group is under pressure or stressed or has a very directive leader or is too cohesive (Annan et al., 2008; Cook et al., 2001; Harris, 1999). Harris (1999) in his qualitative observational research of actual child protection case conferences and interviews with professionals from a number of agencies summarises all of these factors and the consequences in his research:

‘The evidence cited above - the inequality of contributions, the constraints on open debate, the lack of 'science', the need to accomplish other tasks and so on, suggests strongly that multi-disciplinary meetings such as child protection case conferences may fall far short of a rational, optimum ideal in terms of decision-making. Indeed, the evidence indicates that the prime (if well-hidden) function of such a meeting may
be to contain professional anxiety and provide support for the role and responsibility of the lead agency through the promotion of a non-conflict norm. This is in line with the social psychology research cited earlier which predicts that such normative influence will be critical when groups have difficult/stressful decisions to make which involve judgements rather than demonstrably correct solutions. The pre-eminence of the chair’s role and influence also seems to illustrate one of Bion’s ‘basic assumption’ states that a group may adopt to manage its anxiety - that of dependency on its leader (Bion, 1961).’ (p. 251)

3.17.2. Power differentials

Harris (1999) also identifies power differentials as an issue in a study of child protection case conferences. This includes such factors as who decides the practicalities of the meeting including where meeting takes place, the seating arrangements and who chairs the meeting and the organisational differences between people. Laming (2003a) identified status differences, such as between paediatricians and social workers, as an issue in his inquiry. Becket et al. (2007) also identified the opinions of social workers that status makes a difference in the court process about children’s safety.

It is also well recognised in the world of aviation that status differences can have tragic consequences. In some cases of aeroplane crashes the cause of an accident has been discovered to be that the Captain either ignored what he was told by the First Officer or the First Officer did not say what they knew to be the case. Milanovich et al. (1998) identified status differential as being crucial in this behaviour. Gawande (2010: p. 107) in developing and promoting the use of checklists in surgery includes as the first step that all the surgery team introduced themselves: first name, surname and role to everyone. In these circumstances it is more likely that the team work better together and that a member of the team will feel able to tell the surgeon something he or she has failed to do. Also the responsibility for starting off the checklist routine is given to one of the nurses and they have the power to insist this step is carried out at three points in the surgery. Morrow et al. (2005) point out the importance of acknowledging and preparing for changes in status in effective team work within multi-agency working. They had found in their study within Sure Starts that this theme came to the fore and influenced how comfortable and in fact how uncomfortable some people felt about speaking out in decision making forums. These groups were quite large – potentially 33 people.
3.18. Beliefs / models of understanding / models of practice
I explored this issue in my review of multi-agency working and the effect of different beliefs and models on joined up work. However differences between different disciplines impact on the decision making by impeding the process of sharing information in order to come to a conclusion. This can be through different understanding of roles, different language or different models of understanding (Colombo et al., 2003; Frost & Robinson, 2007; Frost et al., 2005; Robinson & Cottrell, 2005). The definition of what the problem is at the start of a decision making process is clearly important. Forrester et al. (2007) in their study of closed cases and allocated cases in London boroughs assess the reliability of 4 categorisations of need. The concept of a main need was shown to be unreliable between two raters. This also has implications in relation to evidence based practice which I discuss in Chapter 4.

3.19. Managing diversity is important
Ovretveit (1995) and Cook et al. (2001) celebrate the fact that multi-disciplinary teams bring together people from different backgrounds and used skilfully can enhance decision making, just as in Chapter 2 it was seen as being important in effective team working. Cook et al. identify the positive effects of different ways of sharing information and the expansion of expertise within teams. This expansion of expertise was achieved through the diversity of professional background both in the immediate discussions but also by reducing bureaucracy and opening up other sources of help. The practitioners identified positive enhancements to their decision making through the sharing of information and expertise especially within the team and the prevention of the delays caused by having to refer out to other teams. Harris (1999) argues that better decisions can be made when there is conflict rather than when there is suppression of disagreement. The importance of managing this diversity of views could be the role of EPs in the opinion of Annan et al. (2008).

3.20. Better decisions
Defining what is the best or correct decision is not straightforward. The issue of complexity discussed above raises the point that there may not be one correct solution or even any correct solution in an absolute sense. Munro (1999, 2005, 2011a) describes the potentially negative consequences of delaying decisions in order to complete an assessment and therefore not offering a service for a clearly
identified urgent need compared to rushing to a decisions and making a mistake by missing crucial information. Harris (1999) quotes three criteria against which to judge the quality of a decision based on Hart (1985) (quoted in Harris, 1999). These are:

‘..outcome (i.e. the result of the decision), process (i.e. the degree of fairness, openness and collaboration in reaching the decision) and content (i.e. the degree of ‘enlightenment’ or understanding individuals have of the reasons for the decisions)’ (p. 246)

He then outlines seven ways to improve the decision making in child protection conferences. These include a chair who leads by valuing correct decisions over preserving harmony and a clear transparent decision making process which everyone understands and accepts.

3.21. Conclusions
Decision making as a research area has produced contradictory results in the detail, but some overarching ideas for which there is general agreement and which are relevant to considering decision making in a multi-agency team working with children, young people and families. There is a clear distinction in the research between decisions made in laboratory type situations and those in real life settings and furthermore differences between decisions made under time pressures and those which take longer and involve more people. However it is clear from the research discussed above that people are not acting as ideal rational agents and all people use heuristics – short-cut methods – which lead to biases and which are outside of their conscious awareness and therefore harder to understand and adjust if necessary. Decision making models have proposed at least two processes one of which is sometimes called intuition and which is fast and automatic and which can lead to errors, but can also produce good decisions. The other system or type, called reflective, is slower, more deliberate and is better for complex situations. Sometimes these two are seen as ends of a continuum but for some they are seen as different systems completely.

Recent theoretical developments and research suggest that practitioners working over a period of time can, through various routes including reflecting on errors, become more expert and therefore can rely more on their intuition. It is important that people have some understanding of their own behavioural and cognitive
processes if they are to make better decisions especially if they are responsible for decisions for or with other people. There are ways to improve decision making and some people improve as they become more expert in a particular field. However all decision makers would benefit from external checks and balances to ensure that decisions, especially in complex situations such as supporting children’s wellbeing, are optimal.

Decision making in groups or teams or in collaboration with other practitioners or with the individuals at the centre was also explored. There are factors which influence decision making in groups which are a function of the social psychology of groups and ideally should be understood by those in groups to avoid the negative impact they can have on optimal decision making. In the helping professions it is becoming a more accepted policy that the person being helped should be at the centre of the decision making. This is not being done to them but with them.
4. **Knowledge**

Decisions require not just a process but also knowledge (Simon, 2000). The Oxford online dictionary defines knowledge as facts, information, and skills. Decision making in the context of this research requires several types of knowledge.

4.1. **Types of knowledge used in decision making**

There is the information available from the immediate environment in which the decision is being made, such as the evidence being collected by a detective or the data on a radar screen or the information about all the different types of car when someone wants to buy a new car. I will call this *case knowledge*. Then there is the *experiential knowledge* which a practitioner acquires through years of doing their job. This might include skills and information and in part is based on the ongoing experience of doing the job and reflecting on the work. Finally there is *research or theoretically based knowledge*. This type of knowledge is acquired through training, reading and other forms of professional development and it is generated by people through a number of methods including systematic research and is most often referred to as evidence as in evidence based or informed practice.

4.2. **Case Knowledge**

This might include data collected in different ways such as through the senses, through conversation, through the use of empirically tested tools. The area of work will to a large extent determine the type of information gathered. For example a detective gathers information when investigating a crime. This can include forensic evidence such as fingerprints, DNA, photographs of the crime scene, bank statements and also witness statements. A doctor would collect information in a number of ways including observations of the patient, asking the patient questions and using medical tests. However the underlying theoretical models and beliefs held by the practitioner will further refine what information is sought and subsequently collected. For example a therapist who is following a psychodynamic model would collect information about family relationships while a solution-focused therapist would ask about times when the presenting issue is successful managed. Therefore gathering information is not a neutral exercise. Furthermore the human capacity to hold information is one of the limiting factors for true rational decision making (Simon, 2000).
4.2.1. **Types of cases for this team**

I discussed in the introduction the types of decisions that practitioners in children’s services might be making. In this research I am concentrating on decision making about interventions. Some disciplines would refer to this as clinical decision making. This project is focussed on children and young people under 16 years of age in the context of school and, depending on one’s professional background, at risk of experiencing “mental health problems” or “behavioural emotional and social difficulties”. In this context case information could mean the type of information required to complete the common assessment framework such as family history, as well as observational records or behaviour records. It could also be information such as psychometric testing of anxiety levels, cognitive ability or working memory.

4.3. **Experiential Knowledge**

Experiential knowledge will vary between practitioners, even those who have been trained in the same discipline. This type of knowledge consists of all they have learned and applied while doing their jobs and from life experience. Some of it will be information from research and theoretical based knowledge but reprocessed through their internal filters. It will be a mixture of factual information, opinions and skills. It will be to some extent socially constructed and not fixed (Wenger, 1998). It is impossible to know all that someone else knows or even all that you know yourself. Some of this knowledge which they struggle to describe in words has been referred to as ‘knowing in action’ (Schön, 2003) or ‘tacit knowledge’, first named and described by Polanyi, (Henry, 2010; Henry et al., 2007; Montgomery, 2006; Schön, 2003). This is knowledge which is not available to be described but they all apply as they live their lives. Some of it is physical knowledge like riding a bike or juggling, however Schön discusses knowing in action that professionals apply, in areas such as design and medicine, but which they could not put into words. This type of knowing or knowledge is generated through learning from the effect of their own actions on the world.

4.4. **Research or Theoretical-based Knowledge: Nullius in Verba (The Royal Society)**

The third type of knowledge is generated from research and theoretically based models which, for most practitioners, is produced by other people in various ways and gathered via training, reading, conversations etc. This is often referred to as evidence, as in evidence based practice. There is also knowledge gained from
systematically monitoring outcomes in practice referred to as practice based evidence, rather than the more informal and less apparent monitoring effect of one’s actions as discussed above. The team in this research as part of the TaMHS project is aiming to operate with an evidence informed approach (DCSF, 2008e), which has developed from the evidence based approach in medicine. Next I will describe evidence based practice in medicine, the advantages and limitations of the approach and then the spread of the approach into other disciplines and the advantages and limitations within these spheres.

4.4.1. Evidence Based Medicine (EBM)

Sackett et al. (1996; p.71) define evidence based medicine as ‘the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.’ They are clear that the doctor is not an automaton matching symptoms to treatment and they state: ‘The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.’ (p. 71)

They define individual clinical expertise as ‘the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice’ (p.71), which is similar to my definition of experiential knowledge and which is developed over time.

In the UK the organisation responsible for systematic reviews of evidence is the National Institute of Health and Clinical Excellence (NICE) which defines evidence-based clinical practice as:

*Decisions about patient care based on the best research evidence available, rather than on personal opinions or common practice (which may not always be evidence-based.* (NICE, 2011)

And that:

*‘Evidence-based’ decisions or recommendations are based on research findings that have been systematically appraised - that is, the best available evidence.* (NICE, 2011)

The quality or reliability of systematic research is usually given as a hierarchy of evidence defined in the NICE glossary as ‘Study types organised in order of priority, based on the reliability (or lack of potential bias) of the conclusions that can be drawn from each type’ (NICE, 2011). The hierarchy of evidence starts with the highest level: a meta analysis of randomised controlled trials, down to case reports
or the clinical expertise of an acknowledged expert (NICE, 2011). These types of
systematic research are based on the view that there are absolute truths to be
discovered and if a sufficiently large sample can be used and with a control group
then a treatment can be evaluated for efficacy (how beneficial a treatment is in ideal
conditions NICE, 2011). In order to be able to measure the efficacy, of a treatment
or intervention, it is necessary to be able to diagnose the disease, therefore there
needs to be a way of assessing a condition which results in an agreed diagnosis
linked to evidence of appropriate treatments. There needs to be a reasoning
process to reach the conclusion that the symptoms being presented are indicative of
a named disease and then there needs to be access to evidence produced
systematically based on diagnostic categories. Compliant patients are also quite
useful when practising evidence based medicine (Montgomery, 2006).

However some writers argue for a distinction to be made between medical research
and medical practice. They argue that practising medicine should take into account
clinical expertise of when to apply what treatment (Henry et al., 2007; Montgomery,
2006).

4.4.2. Do doctors practise evidence based medicine?

Even though the concept of evidence based medicine appears to have been
accepted with such certainty by the bureaucratic apparatus it is not in fact practised
by all doctors. Doctors appear reluctant to change their practice in the light of
research evidence. In a small study Yew & Reid (2008) identified that doctors, three
years after a course which taught the evidence based approach, relied on
colleagues as their main source of information, rather than systematic searches of
evidence. There are studies which show that doctors do not use procedures or
medicines which have been shown to work (Qamar et al., 1999; Reilly et al., 2002;
Sladek et al., 2008). An example is given by Gawande (2003) who writes about his
experiences as a surgeon. He was driven to write about surgeons making errors
because he recognises that surgeons and other physicians are faced with more and
more complex situations and he wants to find solutions to avoid human error. One
solution he proposes is checklists as discussed in section 3.13. Gawande has
started to develop checklists for surgery but even these, whose effectiveness (how
beneficial an intervention is in every day conditions NICE 2011) he has
demonstrated, have not been adopted by other surgeons.
4.4.3. **The reasons some doctors do not practise evidence based medicine**

4.4.3.1. **Criticisms of evidence based medicine**

Straus & McAlister (2000) gathered together the most commonly cited limitations and misperceptions. They conclude that some of the limitations are common to the practice of medicine in general such as the application of research evidence to the individual patient and the difficulties in getting doctors to acquire new skills. There are some criticisms which they say are based on a misunderstanding of evidence based medicine which include the notion that it does not take patients’ values and preferences into account, that it does not value clinical expertise or that it is being used to cut costs by bureaucrats. They feel that none of these are valid when evidence based practice is properly performed.

4.4.3.2. **Epistemological limitations**

Henry et al. (2007) raise a limitation not covered by Straus & McAlister. They suggest that there is an epistemological limitation inherent in evidence based medicine as currently conceptualised. They argue that evidence based medicine cannot take into account elements which resist quantitative analysis. They argue for the acknowledgement of tacit knowing, as proposed by Polanyi, as part of the clinical encounter. Henry (2000) proposes that research should look more closely at patient doctor interactions.

4.4.3.3. **Accessing evidence**

There are a number of reasons why it is hard to access good quality evidence in the field of medicine. The amount of evidence presents a problem:

> an estimated 10 000 new randomised controlled trials (RCTs) are published every year but where an estimated 20%–40% of services still do not reflect the best research evidence. (Waddell & Godderis 2005: p.xx)

There are issues about the quality of evidence for a number of reasons including the hiding of evidence by drug companies (Goldacre, 2010a), the poor reporting of evidence (Goldacre, 2010b) and the falsification of evidence (Goldacre, 2010c).

4.4.4. **Political issues and the evidence based approach**

The issue of evidence based medicine has become a political hot potato. In the UK NICE, which had both the responsibility for reviewing research evidence and concluding what constitutes best evidence and cost effectiveness, may be taken out
of the loop on whether or not a drug is too expensive because of lobbying by patients and the pharmaceutical industry when a drug is deemed too expensive in comparison to its effectiveness (Boseley, 2010). In the USA similar concerns about political interference in professional issues to do with choice of treatments and methods have been raised in the mental health field and in education (Kaplan et al., 2006).

In the UK while the government and the civil service departments have called for increasing evidence based approaches in health and education (Fox, 2002; Fox, 2003), they have also at times ignored best research evidence and relied on anecdotes.

But Ministers and advisers would increasingly meet individual headteachers or academics without the presence – whether moderating or footdragging – of a departmental adviser or senior HMI. This can lead to the uncritical use of anecdotal and partial evidence by Ministers. (Perry et al., 2004: p 36)

Very recently I noticed this quote attributed to Eric Pickles the local government minister in the coalition government.

I’m not interested in research and evidence – I’m here to make decisions. (Maguire, 2010)

4.4.5. Evidence based practice in other disciplines

The concept of evidence-based practice has moved from the world of physical medicine into other closely related fields and also into less closely related fields, including: nursing (Banning, 2005); social work (Gilgun, 2005; McCracken & Marsh, 2008; Munro, 2011b); mental health (Cooper, 2004; Geddes et al., 1998; Geddes et al., 1996; Harrington, 2001; Holmes, 2000; Kaplan et al., 2006; Maier, 2006; Mash & Hunsley, 2005; Ramchandani et al., 2001; Shapiro, 2009; Szatmari, 2003; Tansella, 2002); policy development (Perry et al., 2010); education (Biesta, 2007; Morris, 2009; Perry et al., 2010); and educational psychology (Dunsmuir et al., 2009; Fox, 2002; Fox, 2003; Frederickson, 2002; Miller & Todd, 2002; Moore, 2005; Stoiber & Waas, 2002). In each area there are those who are in favour of the adoption of the approach and those who are critical of it for various reasons.

4.4.5.1. Ontological Issues

Evidence based approaches, which insist on a hierarchical view of evidence, operate within a particular view of reality. This view of reality implies that there are universal truths waiting to be discovered. This idea of reality is challenged by Biesta
Biesta (2007) argues that a strict evidence based approach cannot be applied to education as teaching methods and content depend partly on the purpose of education and that should be part of an ongoing political debate. In addition a concern shared with other fields that values, which some say are ignored in the strict evidence based approach, are an essential part of the process and need to be taken into account (Gilgun, 2005). In the mental health arena Cooper (2004) and Maier (2006) raise the problem of the validity of diagnosis. Cooper is critical of the system of classification used in the Diagnostic Statistical Manual on the basis that whether a condition is a disorder is to some extent a value judgement. Only some of the diagnostic categories can be considered to be a natural kind that absolutely exists and can be observed independently. She argues that classification is theory laden. Maier (2006: p. 327) argues that ‘the evidence-based approach to individual cases is critically dependent on the validity of diagnoses’. Humans are complex systems and a small change in the initial conditions of a complex system can change the outcomes thus nullifying the original diagnosis and rendering research based on the diagnosis invalid. Hence Maier concludes that the process of working with people is different for psychiatrists and psychotherapists than for doctors as the decision making process is more iterative than a one-off critical decision.

If diagnosis presents problems within the mental health field, assessment within social work presents even greater issues. The current child in need assessment has been shown to lack reliability between practitioners rendering the matching of intervention to needs very difficult (Axford, 2010; Forrester et al., 2007). There is recognition that there is no absolute truth waiting to be discovered, instead the assessment is relative and the meaning of needs varies between practitioners and between families. Moore (2005) argues:

There increasingly appears to be an acceptance that the social world and social reality, at least, might not be readily characterised by universally applicable and transcendent laws such as the naïve realism of positivism proposes and that although the world may exist physically independently of people, truth and meaning cannot. (p.106)

Fox (2002, 2003) explores these issues within educational psychology outlining the dilemma as follows:
The tension between those educational psychologists who wish to base their professional practice on subjective experience and self-reflection, and those who wish to base it on a more objective base is explored (Fox 2003: p. 91)

4.4.5.2. Randomised controlled trials (RCT)

As mentioned above RCTs are seen as the gold standard in the medical arena when considering the efficacy of a new drug or other medical intervention. They have also been promoted as the appropriate way to go to measure the efficacy of new interventions in other areas such as education, mental health and, as discussed above, other policy areas. Goldacre (2011), a Guardian columnist whose column is called Bad Science, argues for the use of randomised control trials in all policy areas including education. There are, he reports, examples of trials from education from around the world and we in this country are ignoring the evidence and not conducting proper trials ourselves. I think in his article he glosses over one of the key problems with RCTs in complex situations such as education and schools or mental health and families which is that successfully transferring the intervention into another school or family is not an automatic process. Complex systems respond in unpredictable ways.

Margison et al. (2000) summarise the technical limitations of RCTs for mental health which include the differential attrition rates, poor compatibility of groups, poor outcome measures and interventions delivered differently by different clinicians. It is also a problem that results from RCTs are poor predictors of outcomes at an individual case level.

There is an acknowledged problem within the child and adolescent mental health arena with the hierarchy of evidence. Concerns include the lack of evidence of this type because of ethical issues with conducting randomised controlled trials in the settings in which children and young people are encountered by practitioners and the application of interventions in practice which have been conducted in controlled conditions. When an intervention is delivered in a RCT, the way it is delivered is usually tightly monitored with practitioners trained closely to deliver it in a very set way and this is rarely achieved in real life settings (Frederickson, 2002). Instead of a fixed hierarchy with RCT at the top Ramchandani et al. (2001) suggest linking the appropriate research to the type of question which is being asked.
If RCTs are not wholly appropriate in fields such as CAMHS, education and social work then how does the individual practitioner find best evidence to apply in individual cases? This issue has been directly addressed by Pawson & Tilley (1997) and comes from the critical realism paradigm. In this approach the researcher has to be clear about their values, the context they are researching, the link between the tools they are using and the type of knowledge they are creating (Coolican, 2004; Kelly et al., 2008). Pawson and Tilley argue that using their approach to evaluate programmes is necessary because it takes into account the relationship between the mechanism (programme content) and the context in which it is being delivered. This takes a generative view of causation as opposed to the positivist successionist view (Robson, 2011). With the realist approach they argue it is possible to identify what works in what context (Pawson & Tilley, 2008). I discuss the critical realist approach further in my methodology chapter.

4.4.5.3. Further issues with evidence based approaches

Other fields face issues in applying an evidence based approach. These include the difficulty of accessing and using good quality evidence, the complexity of the problems being worked with and the difficulty in persuading practitioners to change their practice and adopt new methods (Frederickson, 2002; Gilgun, 2005; Morris, 2009). Morris (2009) talks about attempts to bring research evidence to teachers which have fizzled out and he lists other factors that stop people rationally applying evidence to practice which include ‘difficulty in locating relevant studies; the inaccessibility of research language; conflicts with existing knowledge and beliefs; lack of time, resources and support.’ (p.33) He suggests research is more likely to be applied if it is ‘relevant and timely; has clear and uncontested findings; comes from a credible and trusted source and was conducted within the context of its future use’. (p.33)

Whilst acknowledging the strides forward in the availability of research evidence Davidson (2008) identified barriers to the application of evidence based practice within child mental health services.

‘In addition, our literature review found that practitioners face other barriers, including: significant gaps in the evidence within their field; some resistance to using evidence from other professional sources; a lack of understanding of what the evidence means for their practice; and a lack of inspirational leadership, training and supervision.’ (Davidson, 2008: p. 90)
4.4.5.4. **Accessing and using the best evidence**

Best evidence is often hard to access. As in the field of physical medicine there is a vast array of sources of evidence which the average practitioner would struggle to find time to locate never mind read and then adapt their practice to deliver (Morris, 2009). The sheer quantity of information which could be relevant is illustrated in just one six page article by Hansen (2010). This is a summary of sources of evidence for practitioners working in the area of early childhood. There are sixty references and/or websites. In some cases they may lack the statistical skills to be able to criticise quantitative data (Perry et al., 2010). Gathering best evidence is not an easy task. Properly conducted research is not easy in the real world. There are several different institutions identifying and assessing best practice. The National Institute of Clinical Excellence, the Cochrane Library, the CAMHS Outcomes Research Consortium (CORC) and the CAMHS Evidence-Based Practice Unit at The Anna Freud Centre, all approach this area from the medical world. From the educational or social sciences world there are amongst others: The Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre) and The Centre for Child and Family Research (CCFR), an independent research unit.

The Triple P Positive Parenting Programme is an example of a programme which has both a theoretical base and an empirical base (Sanders et al., 2003). They also control the training of practitioners very closely. However they are not around when this is delivered and available to help practitioners adapt the materials to their particular setting.

4.4.5.5. **Complexity and evidence based practice**

Morris (2009) highlights another constraint on the use of evidence and this refers back to Simon and bounded rationality. He argues that problems are so complex that there are too many variables and too much information for people to hold all of this information in their heads and make rational decisions. Gawande (2010) is also concerned that doctors have too much to hold in their heads.

4.4.6. **TaMHS – Evidence Informed Practice**

Even with all the concerns offered above there are those who present strong ethical arguments for the use of evidence based practice in child psychiatry. Szatmari
(2003) maintains that not to use the best available evidence when intervening with a child and family is unethical. He is adamant the art of clinical practice should not and does not rely on ‘intuition, imagination, opinion or fancy’ (p.1000). Clinicians who argue that their clients are unique and research evidence does not apply to them are in his opinion falling into a logical fallacy. Best evidence has to be extracted from all sources and should be adapted to the unique child or family. In agreement Harrington (2001) concludes that:

‘The families and children who come to us for help have a right to expect that the interventions on offer have been properly evaluated and that, at the very least, they will leave our services no worse off than before they came. Good randomised trials are an important part of the process of ensuring that this occurs’. (p.65)

The team at the centre of my research have been enjoined to use an evidence informed approach. The aim as stated is to deliver early intervention based on the evidence. The definition of evidence informed practice is

‘Interventions for children and families at risk of and experiencing mental health problems, which are planned according to local need and grounded in our increasing knowledge of what works’ (DCSF, 2008d: p. ii).

It is a summary of existing knowledge about effective interventions for children and young people experiencing mental health problems offered in a document for headteachers and commissioners. This document is explicitly not designed for the individual practitioner to decide which intervention to use with which child. However the intention as expressed in the aims of the project is that practitioners will use ‘evidence based models of therapeutic and holistic early intervention mental health work with children and families’ (DCSF, 2008d)

4.5. **Integrating all three types of knowledge in decision making**

Assuming therefore that all practitioners want to do the best job they can the question becomes how to integrate all three types of knowledge I have discussed into the decision making process. To make good decisions Waddell & Godderis (2005) argue that:

‘Thoughtful work in children’s mental health research and practice always comprises a synthesis of multiple forms of evidence: individual experience (of the one researcher or practitioner, or the one child or family), aggregate experience (of the many children and families), qualitative evidence (about values, meaning, and preferences) and
Shapiro (2009) discussing psychiatry recommends that practitioners need to find ways to combine knowledge from research, which he argues has been improved since the first criticisms were raised, with a clinical reasoning process. He discusses what this is like in practice and describes the type of experience discussed above in decision making and intuition. He recognises patterns in what his patients are telling him and he matches these patterns to research under diagnostic categories.

Munro (2011) is quite clear that “Good professional practice is informed by knowledge of the latest theory and research” (p. 38) and she recommends the use of ‘best evidence’ (p.38) and the time to integrate new learning into practice. She incorporates in her discussion the need to adapt best evidence into practice which she categorically states will not involve taking a readymade intervention off the shelf and applying it to families but instead says good evidence based social work practice will require the skill to know when to apply what intervention to what situation.

The concept of evidence based practice has been discussed within educational psychology. Annan (2005) places at the centre of her decision making process the use of evidence. In the description of situational analysis the word evidence is used in a broad way including all three types I have described. In addition she emphasises the use of outcome measures using both objective and subjective information as a check on an intervention within a particular case.

4.6. Practice based evidence

One way of ensuring the development of both experiential knowledge and research knowledge is by accurately and systematically measuring outcomes after intervention (Margison et al., 2000). Dunsuir et al. (2009) describe one method for this, Target Monitoring and Evaluation. Support for the rigorous evaluation of interventions is given by Frederickson (2002) promoting the role of educational psychologists using goal attainment scaling.

A commitment to researching our own individual practice may be the starting point for an evidence-based profession. (Fox 2003 p. 101)
Mash & Hunsley (2005) discuss the concept of diagnosis in the context of child assessments in child and adolescent mental health. They suggest that an assessment may not use a formal diagnostic or categorisation system. However they do recommended that an assessment should allow problems and the effect of interventions to be tracked over time and therefore does need to be systematic.

4.7. Conclusions
Practitioners within children’s services have to find ways to weave together the three types of knowledge, discussed here, in their decision making. It is clear from the previous discussion that in a complex system this is not an easy process and practitioners of all disciplines need to be trained and open to developing their practice in light of new best evidence. In addition, given that interventions have to be delivered in situations other than controlled settings, it would be best that there is a way to measure outcomes in order to monitor the effects of interventions and the use of supervision to monitor practice and to help practitioners to learn from their experiences.
5. **Methodology**

5.1. **Research Position**

In this chapter I will describe the theoretical underpinnings for the research, the research design, the data collection and analysis and the advantages and limitations of this design. I will also reflect on my own thinking within the context of educational psychology practice and research.

As discussed in Chapter 1 part of my journey in this research has been to reconcile my original training in a positivist tradition with my developing ideas about the nature of reality. My training as an educational psychologist took place the year after the publication of a seminal work in educational psychology - *Reconstructing Educational Psychology* (Gillham, 1978). The book expressed the concerns of a profession unhappy with an essentially positivist approach involving a child deficit model and moving towards an approach which recognised that children, their behaviour and problems, could not and should not be viewed as independent of the systems in which they lived their lives. Within the practice of educational psychology the debate continues to this day as there are still aspects of the job which derive from a positivist position, e.g. assessing children using standardised cognitive tests, and those which derive from a constructivist position, e.g. consultation (Kelly et al., 2008; Moore, 2005). In the practice of educational psychology the interesting conundrum has been raised that the clients often had a positivist view of reality while educational psychologists may be holding a relativist view (Fox, 2002; Matthews, 2003). My approach in my professional practice is to take a position somewhere between the two extremes.

Critical realism offers a third way between extreme positivism and extreme relativism (Sayer, 2000) or as Kelly et al. (2008: p. 24) describes it ‘an integration of positivist and relativist positions.’ This view of reality provides a position from which to conduct my research even though most decision making research has come from within the positivist/empirical tradition. This is taken for granted and the researchers rarely state their positions (Croskerry, 2003; Kahneman, 2003; Simon, 1986; Tversky & Kahneman, 1974). Positivism maintains that there are fundamental laws and absolute truths to be uncovered (Willig, 2008). The hypothetico-deductive approach arising from empiricism has become the dominant research paradigm in the natural sciences, which involves the scientist forming hypotheses from previous
observations or theories and then testing them by experiment (Grayling, 2010). In
the field of decision making researchers conduct experiments and report their
findings as universal laws applying to all human behaviour (Kahneman, 2011; Klein,
2008). However as I discuss in the review of decision making (sections 3.4 and 3.5)
one of the dilemmas for decision making researchers has been the perceived
necessity of moving out of the laboratory into real life settings to uncover how
people made decisions in the real world. The Naturalistic Decision Making paradigm
was developed because researchers were dissatisfied with the extent to which
laboratory based research explained decision making in real life settings (Lipshitz et
al., 2001). The contrast is drawn between laboratory type research where
experimental variables can be controlled and field research in real world settings in
which they cannot be controlled. They are closer to the view of reality shared by
scientific realists (Nash, 2005) who argue for the place of statistical modelling to
uncover causal mechanisms in the relationship between e.g. poverty and
educational attainment.

Realism provides a way of approaching research in real life situations (Robson,
2011). Critical realism, unlike an extreme relativist position, maintains that there is a
“real” world out there to discover but that data might not give direct access to this
reality (Willig, 2008). Critical realism assumes that there is an objective view of
reality and that it is possible to prefer one account over another (Pawson & Tilley,
2008) but that an interpretation may be subject to error (Kelly et al., 2008;
Matthews, 2003; Robson, 2011). I am assuming that there is a shared view of reality
between people but I acknowledge that my interpretation may not be accurate and
therefore I check my interpretations with the participants.

I agree with Sayer (2000) who argues that the objects of study of social scientists
are concrete but that social systems are complex and open and that the different
components cannot be isolated and controlled unlike in some of the natural
sciences. In critical realism the positivist view of causation does not apply (Robson,
2011) instead as discussed in section 4.4.5.2 there is a generative view of
causation which proposes that in order to produce a particular outcome then the
conditions have to be right. Therefore critical realist research in the social sciences
sets out to uncover the mechanisms which are operating in a particular context to
produce particular outcomes. How people behave cannot be separated from the
contexts in which they live (Coolican, 2004). The critical realist would argue it is necessary to describe the context and to look for mechanisms which need to be present to produce a particular outcome. This research is aiming firstly to build up substantial knowledge of decision making in multi-disciplinary teams and secondly to identify possible mechanisms associated with decision making.

In this research I am studying decision making in a real life context with the intention that I create a rich picture of this decision making process in this context. This has not been done before in a multi-disciplinary team working with children. In line with a realist position I do not expect to uncover universal truths which would apply to all decision making, however my interpretations of the data will provide the first stage in describing possible mechanisms which could then be tested in other multi-disciplinary teams working with children.

5.2. Reflexivity

In conducting research it is important that a reader understands the context of the author (Boyatzis, 1998; Robson, 2011; Willig, 2008). It is even more important that the researcher develops awareness of their own influence on the research process as it is the researcher’s interpretation of the data which stands as the end product (Hennink et al., 2011). A critical realist stance as discussed above assumes that there is an objective view of reality but that view is “filtered through the lens of whoever is conducting the research” (McLeod, 2011). In adopting this stance I have considered both my personal story and my influence on the interviewees based on our prior relationships, these two facets of reflexivity can be called personal and interpersonal (Hennink et al., 2011). I have ensured that throughout this thesis I have described and reflected on my professional identity and experience, the origin of my interest in decision making and the possible expectations and biases which could arise from this. As I have been interested for more than ten years in the place of what authors have variously described as intuition, gut instinct or tacit knowledge within my decisions, I have tried to be careful not to go looking for intuition or in some other way impose my beliefs on the participants. In section 5.5.4 I describe the process of recruiting the interviewees and the care I took to ensure they were willing participants. My interview skills, which to some extent I may take for granted, have developed over the years in my job and I am very used to creating a relaxed
atmosphere in which people feel heard and understood. This I believe explains the comprehensive data I gained from the interviewees.

I have kept a research diary in which I recorded my own impressions as I conducted the study. I recorded key steps in the research process from the initial discussions with the team manager and my supervisor, throughout the data collection and analysis, and during the write up (Frost, 2011). I found this helped me in practical ways to keep track of the research process, to develop models and thematic networks and to monitor my own thinking as it developed. I did not systematically analyse it using thematic analysis (Robson, 2011).

For this piece of research it is important to define some terms, not least because the research lies in the border territory between different professional areas. There will always be border areas. As I have discussed in the literature review it is not only inevitable but essential that those working in the helping professions with children and young people work together. It is hard to be absolute in the definitions as language is changeable and the same word can have multiple meanings or for some people unacceptable connotations. Just one example of that is the word diagnosis which originates from within the medical model. I have my own language based on my understanding of to the type of world I live and work in, the training I have received and my experiences in work and elsewhere. I do not use the term diagnose to describe my own practice. However as I operate within a system where other professionals do diagnose and often families ask for a diagnosis there are occasions when I have to explain my position and still maintain relationships with families and colleagues.

In this research I am aware that even if I try to define all the possible meanings of the terms I use here I will still not be totally transparent. It is inevitable that people will hold different meanings for the same terms and use other terms I have not used. Meanings of words are not absolute; they are socially constructed and develop different shades of meaning for different people. To help the reader to understand my meanings I include a glossary of terms on page 16.
5.3. Research Design

Taking a critical realist stance is compatible with a wide range of research methods (Robson, 2011; Sayer, 2000; Willig, 2008). In this research I am using a case study design, mixed method qualitative data collection and thematic analysis. Yin (2009) recommends the use of a case study design when: “how” and “why” questions are being posed, the researcher has little control over events and the research is exploring current events in a real life setting. Although in his view a properly designed case study can offer explanatory answers in this research I will be mainly descriptive and not explanatory. The research questions are designed to allow the gathering of rich data about this particular team in this particular authority. I have included a description of the team, the context in which they work and the participants in Chapter 6. Although this case may not be representative of others and therefore the findings should not be assumed to apply to teams working elsewhere, my interpretations of the data could provide possible mechanisms in critical realist terms that might potentially apply to other teams (Willig, 2008). My interpretations may then be useful for other teams with similar features to this team.

This study is not an evaluation of the effectiveness of this team. There is a national evaluation of the TaMHS project being conducted and within the team locally there is evaluation of outcomes for the children. I will not be able to link my findings to outcomes for children.

I am using semi-structured interviews, non participant observation and a collection of team documentation which will allow triangulation of views. All of which are consistent with a realist position (Robson, 2011). I am not obliged to reach a sample size to ensure statistical reliability because I do not want to generalise to other population samples. As I do want to explore decision making from each professional background within the team, I have applied purposive sampling (Coolican, 2004; Hingley-Jones & Allain, 2008) and have chosen one interviewee from each discipline as well as the team manager. I describe the development of the interview schedule in detail in section 5.5.3.

It had been my intention to follow-up the interviews with focus groups to explore some initial hypotheses with the participants. I had intended to use them to check on my interpretation of the “how and why” parts of research questions 2 and 3. Very
sadly just as I was reaching that part of the study the team were informed that some members would be made redundant and, after discussions with their manager, my supervisor and the team I decided not to conduct the focus groups. Instead I was able to check out some of my interpretations by giving feedback at a team meeting, by giving individual feedback via emails to the interviewees and by meeting the team manager to discuss my findings.

My observation of the cluster meeting allowed me to check the interview data against a sample of decision making as it happened rather than as a retrospective memory task the implications of which I discuss further in section 3.5. I took a non participant role but I accept that my presence would have altered the dynamics of the meeting to some extent. This can be a problem for some ethnographic researchers but I am taking the view that an observation is another way to expand my understanding of this team’s decision making process in conjunction with the checks I describe above (Robson, 2011).

Also as this is an exploratory study the pointers given in the interviews could lead to further studies. I have to be careful not to extrapolate my findings too far. A number of other data collection methods could have been used such as questionnaires, but these would not have allowed the flexibility to explore points with individuals in more depth; more observation, which would have taken more time; or an examination of case files which would have led to additional ethical issues.

Thematic analysis is generally seen as a research tool which can be used within a paradigm anywhere on the continuum from positivism to social constructionism (Boyatzis, 1998; Braun & Clarke, 2006). It is entirely consistent with a critical realist design and has been used within educational psychology research from within critical realist position (Landor, 2011; Osborne & Alfano, 2011). Braun & Clarke (2006: p. 79) describe thematic analysis as ‘a method for identifying, analysing and reporting patterns (themes) within data.’ They define a theme as ‘a repeated pattern of meaning’ (p.86) and from a critical realist point of view the meaning can be common across a number of people. I chose to apply the thematic analysis approach as described by Boyatzis (1998), consisting of a codebook system in which the themes are defined and examples given as I believe this gives a more public way to check on my interpretation of the data than that recommended by
Braun & Clarke (2006). However, as my research is focused on research questions which are exploratory and not designed to distinguish between teams or practitioners, I did not use the thematic code developed to distinguish between samples (Boyatzis, 1998). I used my research diary to chart my work and as a tool for reflexivity. I did not submit the diary to a systematic thematic analysis (Robson, 2011).

I did not use a predetermined theory to guide my data collection and analysis, such as Activity Theory (Edwards & Fox, 2005; Leadbetter, 2005) or Communities of Practice (Wenger, 1998). I decided that I wanted to remain open to possibilities rather than to look for concepts and themes preformed.

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<thead>
<tr>
<th>Research Questions</th>
<th>Data Collection</th>
<th>Method of data analysis</th>
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<tr>
<td>1. What is the process of decision making around the choice of intervention for individual children?</td>
<td>Local Documentation&lt;br&gt;Team manager interview&lt;br&gt;Team member interviews&lt;br&gt;Cluster meeting observation&lt;br&gt;Feedback from the team&lt;br&gt;Feedback from the team manager</td>
<td>Thematic Analysis&lt;br&gt;Development of a descriptive model</td>
</tr>
<tr>
<td>2. How do team members conceptualise the circumstances that children and families and schools experience and why do they use these conceptualisations?</td>
<td>Primarily team member interview 1&lt;br&gt;Cluster meeting observation&lt;br&gt;Feedback from the team&lt;br&gt;Feedback from the team manager</td>
<td>Thematic Analysis</td>
</tr>
<tr>
<td>3. Why do the team make particular choices of interventions and what influences the choice of interventions?</td>
<td>Primarily team member interview 2&lt;br&gt;Cluster meeting observation&lt;br&gt;Feedback from the team&lt;br&gt;Feedback from the team manager</td>
<td>Thematic Analysis</td>
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Table 1: Research Questions and Methods of Data Collection and Analysis
5.4. Quality of Research

When conducting any type of research it is necessary to ensure that it reaches a satisfactory level of quality. Ways of measuring quality depend on the research paradigm being followed. Research studies within a positivist paradigm are expected to show reliability and validity. Different qualitative research paradigms have different views on these concepts (Coolican, 2004). A qualitative piece of research should show consistency from the original choice of theoretical paradigm, through methods of data collection and methods of data analysis to the final written results. I have taken a critical realist position which is consistent with the methods or data collection and the analysis.

Yin (2009) recommends a number of ways of ensuring validity and reliability. To ensure construct validity in a case study he recommends multiple sources of data, with an established chain of evidence and with a participant check of the draft report. I have achieved the first two, but not the third, by interviewing several people, observing the cluster meeting and examining local documentation with a participant check of the themes and the models. To ensure internal validity he recommends pattern matching, explanation building, addressing rival explanations and using logic models. I have used the first three but not the fourth as he defines it. To ensure external validity he recommends using theory in single cases. In my results I link my explanations to theory. To ensure reliability of data collection I used interview schedules and a template for the cluster group observation.

Boyatzis' (1998) recommends consistency in three areas: the raw material, the code development and in the interpretation. To ensure consistency of raw material I used the same two interview schedules for all the interviews. During the interviews I did not use all of the prompts but only those which were needed to clarify what the interviewees were saying. I used the same headings from the interviews to develop the template I used for the observation of the cluster meeting. To ensure consistency of code development I used the process of code development to compare and contrast the descriptions including the NVIVO function Matrix Code Query. I also discussed the codes with the team manager and used her feedback to adjust the models and networks. To ensure consistency of interpretation I looked for themes which were identifiable in all the interviews and checked these with the observation of the cluster meeting. I also asked for feedback from the whole team.
and each interviewee for my initial ideas. I also discussed my interpretations with the team manager. In a previous research paper using thematic analysis I used the Braun & Clarke’s (2006) checklist to self reflect on the quality of my research. In Appendix 12 I have included a checklist for this study using their categories.

This all contributes to the validity or, in Lipshitz et al. (2001) terms, the credibility of my analysis. They also recommend consistency in the naturalistic decision making research paradigm (Lipshitz et al., 2001) and conclude that credibility and transferability criteria should be used. By credibility they mean that the research questions, methods of collection and analysis should all be consistent. The assumptions underlying the methods used should be reasonable. They conclude that these rely on the judgement of the researcher. Transferability is for them not the same as extrapolating results from a sample to a whole population based on statistical analysis but rather that there are similarities of features between situations. This would then lead to the view that it essential to develop a thorough description of the features of the arena in which the decision making is happening. This should include the people as well. However it is important that the transferability of the findings is not overestimated.

5.5. Methodology: Data Collection

5.5.1. Ethics

I gained approval for the study from the university research and ethics committee. I arranged to attend a team meeting and explained my research rationale and the procedures to the team. An information sheet was distributed to the whole team. Confidentiality was ensured and participants were informed they had the right to withdraw at any point in time. The members of the team were given time to consider their decision and then signed a consent form (Appendix 1). Ethical concerns regarding disclosure of information of either a sensitive or professional nature were discussed and participants were assured regarding anonymity and confidentiality. I outlined the only situation in which I would go to their manager which was if they disclosed anything which suggested they were putting themselves at risk or a child at risk. At the start of each interview and the observation, I again reminded the participants that they could withdraw. I explained the recording and again checked if they gave their consent for a recording.
5.5.2. **National and Team Documentation**

I gathered together documentations from the national TaMHS programme and from the local programme (those not referenced are in Appendix 2). I did not have access to documentation of case work.

5.5.3. **Semi-structured interview schedule development**

I developed an interview schedule with prompts to check for meaning and understanding (Coolican, 2004). Choosing to use a semi-structured interview schedule ensured that all participants were asked the same overall questions with prompts and probes to elicit information in greater detail. The use of “why” questions about decisions was avoided in part to avoid the likelihood that participants would close down their answers (Coolican, 2004) but also because it is likely asking them to remember their motivations at the time would not produce reliable results. I also avoided the use of the word “why” as I thought it might lead them to feeling as though they have to justify their decisions, which is something I wanted to avoid. Interviews can be an unreliable method to find out what people did and why they did it. Introspection about decisions directly is not an effective way to elicit information about how people make decisions (Fischhoff, 2010). I expected that by asking for a case description that the participants would describe the case in such a way that their decision making would be reconstructed during our interview rather than that they would be trying to remember in detail “who did what” and “why”. It is very likely that the participants will not have remembered events with complete accuracy, however through the use of triangulation and participant validation (Willig, 2008) it is possible to determine whether their description is reasonably accurate. I make the assumption that the process of recounting a particular case would illustrate the participants’ general way of working. However I also recognise that some of the process of decision making is outside the awareness of participants.

The development of the interview schedules went through a number of stages. In the planning for the project I had met with the team manager on two occasions to discuss the idea of research involving the team. I then developed an interview schedule to use in my first interview with her (Appendix 3). I used this interview to develop the schedules for use with the team members. I practised using these interview schedules and a tape recorder with a colleague. I finalised the schedules following this practice session. The first interview (Appendix 4) concentrated on how
the participants conceptualise the circumstances of the children, families and schools. In the second interview (Appendix 5) I asked them to recall a case, having given them notice before the interview to be prepared for this, and to describe the decision making process as they remember it. The prompts in the interviews were designed to allow the participants to reflect as they talked to me. I chose to ask them to talk about a successful case with the intention of reducing any tendency to say what they thought I might want to hear.

5.5.4. **Interviewee recruitment**

Besides the team manager I asked 6 team members, one from each of the six roles within the team, if they would agree to be interviewed twice by me. Throughout this process I was careful to give those I asked an opportunity to say no. As I have explained above I am known to the participants. I am not in a direct line management position but at the start of the TaMHS project I chaired the operational group and delivered training to some of the team. This role had ended before the start of the research. I was therefore extremely careful to ensure that none of them felt constrained by our pre-existing relationship to participate. I have I believe positive working relationships with them all. All of those I asked said yes. I arranged times which were least intrusive to their work.

5.5.5. **Interviews**

I am very familiar within my job on how to create a relaxed and comfortable atmosphere for interviews. During the course of both interviews the aim was to encourage the participants to reflect on their thinking and practice. It is my belief that I have a positive working relationships with the team members and that this was helpful in encouraging them to discuss their work in-depth. Although I have no external confirmation of this I think they were prepared to describe some aspects of case work which had not gone as well for them. It was clear within the course of the interviews that participants found the process tiring but enjoyable. In some cases they expressed the view that the subject was unusual for them to explore in such depth, but that it was interesting and something they should do more often.

I conducted 15 Interviews in total. 12 Interviews took place with team members and 3 Interviews took place with the Team Manager, 1 before, 1 after the 12 team interviews and 1 after data analysis. 13 of the interviews were recorded on tape
recorder and were then transcribed by a typist. The last interview with a team member was delayed due to illness and this then delayed the second interview with the team manager. The second two interviews with the team manager were not recorded due to problems with the technology. However a summary had been produced for the interview and notes were taken during the interview and these were shared with the manager who checked them for accuracy and added some further thoughts.

The range of durations for the team members’ interview (not the manager’s) was from 39 minutes 39 seconds to 56 minutes 31 seconds. The total duration was 590.73 minutes. The mean time was 49.23 minutes. The manager’s first interview lasted 57 minutes 20 seconds. I use this data to illustrate that the interviewees were not brief chats but instead in-depth explorations of the participants’ thinking about their practice. All the interviewees were happy to talk for this length of time.

5.5.6. Feedback to team and from team

I fed back my initial thoughts to the team as a whole at a team meeting. I asked for feedback on post-it notes from the team. I asked explicitly for their views on my understanding of the data at this point. I also used this as an opportunity to identify gaps in the data. This helped to ensure that the original sample had not resulted in a bias of views and it allowed me to check the authenticity of my interpretation.

5.5.7. Observation of Cluster Meeting – Observation schedule development

My choice of which cluster meeting to attend was not random but it was also not deliberate. Rather, the choice was opportunistic, in the sense that after finding out when the next meeting for each cluster was due to take place I chose the one for which I had space in my diary. I took notes based on a template (Appendix 6) designed with the research questions in mind and with a view to helping me keep an accurate record of the meeting. I decided to use a format of one page per child. I did not tape record this meeting as the names of children were being used with personal and sensitive information being shared. I did not use names at all in my notes. I was a non-participant observer. I did not ask clarification questions as I did not wish to influence the process or disrupt it. I am not in a position to know how much my presence affected the content of the discussions. I would be naive to suggest that I did not affect it. However as a check of the process as understood through the interviews it was very useful. Two of the people at this particular
meeting were interviewees and two were not. One usual attendee (the social worker) of the meeting was absent.

The meeting started at 1.30pm and finished at 4.15pm. Thirty nine children from two schools were discussed. Each case was discussed for an average of 4 minutes. Most of the cases were open, some were near to being closed and a few were new referrals. I was therefore able to observe discussion taking place at the beginning of a case, during a case and at the end of a case.

5.6. Methodology: Analysis of data

I uploaded the interview transcripts and recordings, my observation notes and other documentation into NVIVO (version 8) which is a qualitative data analysis computer software package produced by QSR International. There are a number of functions within NVIVO which I used to facilitate the process of analysis. The terminology and uses for those functions and my definitions are in Appendix 7. As can be seen below this was an iterative process, leading to conceptual networks and models.
5.6.1. **Analysis Round 1: Initial Theme Extraction and Participant Validation**

![Figure 2: Analysis Round 1](image)

Before the transcripts were returned to the interviewees I listened to each tape with the document open and corrected typing errors. During this process I took notes for my initial thoughts about the process and themes. This period was very useful for forming my first impression about the decision making process (DMP), the conceptualisations used by the interviewees and the influences involved. I wrote up these initial thoughts and returned for a second interview with the team manager and asked her for feedback. Using this feedback I gave feedback to the whole team on my research and asked them to comment on my initial thoughts. This feedback included a list of all the interventions the team could offer and access. As well as providing an opportunity to check my initial interpretation of the data with the team, the team manager and I agreed that the feedback could be used for team development. I typed up their comments and returned this to the team and added these notes to my sources. All transcripts were returned to the interviewees with my initial thoughts about their interviews. I asked them to check these and to let me know if they were happy with my initial thoughts. I received feedback from 4 interviewees in emails and from the other 2 orally.
5.6.2. Analysis Round 2: Developing Themes and Code

The initial nodes (themes) were derived from my literature review and my initial reading of the transcripts and listening to the tapes. I was open to discovering surprising themes. In other words I tried to keep an open mind and not to be restricted by my reading and own biases. I identified themes and using the free node facility in NVIVO I collected text examples of the themes from all the interviews. I started to assign labels and descriptions.

Figure 3: Analysis Round 2
5.6.3. Analysis Round 3: Code consistency checked and network development

I then reread all of the second interviews and checked my initial themes against these transcripts. I assigned text from the second interviews into the nodes. At this point I started to look for clusters of themes and using the tree node facility I brought the themes together into networks of overarching themes and subordinate themes. I then developed thematic codes for those networks and used these to code all the interview transcripts.
5.6.4. **Analysis Round 4: Using the Observation Notes of the Cluster Meeting**

In Round 4 I reread the observation notes of the cluster meeting. I used these notes as a way to check my developing theme networks. I refined the descriptions for each of the themes. I started to develop models using the NVIVO drawing board.
5.6.5. Analysis Round 5: Research Question 1 Model Development and Codebook Finalised

I concentrated on Research Question 1 in this round of analysis. I drew and redrew models to describe the DMP. It was at this stage that my interpretation of the data produced a multilayered representation of the DMP. I finalised models for each level and where appropriate finalised descriptions for themes. For the actions level of the DMP I searched for examples of actions.
5.6.6. Analysis Round 6: Research Question 2 Model Development and Codebook Finalised

I reread all text coded to the original free codes and tree nodes related to research question 2. I assigned all free nodes (themes) to the tree nodes (thematic networks). I analysed all the interview text in those areas describing the children and those areas describing the interventions. I used the Matrix Coding Query function to check on consistency of coding. I discuss this further below in section 8.1. I arranged the network into a diagram. I finalised the descriptions for each of the subthemes.
In Round 7 I concentrated on Research Question 3. I reread the second interviews concentrating on those parts of the narratives that described decisions about what to do next and the questions about what would stop optimal decision making. I then checked all the text I had grouped under influences and started to separate these into different subthemes. I then compared these themes and subthemes with the cluster observation notes. I used the model function to create a diagram to illustrate the thematic network. I finalised the description for all the themes.

I had checked the list of interventions with the team members during Round 1. I edited the list based on their feedback. The list is in Appendix 8.
5.6.8. **Analysis Round 8: Model Finalisation and Participant Validation - Team Manager**

Once I had completed models for each of the research questions, I shared them with the team manager. Due to the particular developments within the local authority and the ending of the TaMHS funding, I did not think it was appropriate to return to the whole team. I took notes during the meeting as we went through the diagrams in numerical order. I then edited the models as appropriate in line with her feedback. However, in the main she agreed with my descriptions and interpretations as outlined in the models and thematic networks.
6. CASE STUDY: A MULTI-DISCIPLINARY TEAM IN A NORTH WEST LOCAL AUTHORITY

6.1. Demographic Background and Policy Context

The following information has been collected from a number of sources, including local documents and national documents; however some information is from my personal observations. I have worked in this LA since 1999. This LA became a unitary authority in 1998. It is a high density authority of high deprivation with a population of around 142500 in a small 6 miles by 3 miles area. In 2007 it was ranked the 12th most deprived of 354 local authorities in England. The local Children and Young People’s Plan 2009-2010 describes in detail all the barriers to achieving the five ECM outcomes within the authority. There are high concentrations of sub-standard housing. There are high levels of transience both from other parts of the UK and within the town itself leading to low levels of community support. Life expectancy for men is the lowest in England and causes include alcohol related diseases, circulatory diseases, cancers (especially lung cancer), accidents and self harm, and respiratory diseases (Bxxxxxxx Children’s Trust, 2009; Rajpura, 2010; Rajpura et al., 2009).

This brief summary describes just some of the developments within this LA linked to the national policy themes. As an area of high deprivation this LA has often been amongst the recipients of the funding designed to target areas of high deprivation and high social exclusion. One of the first projects set up after this authority became a unitary authority was designed to identify children missing from school and likely to be at risk of social exclusion (May-Chahal & Broadhurst, 2006). In line with national themes access to education is seen as a way to overcome other risk factors. A tiered approach for CAMHS was developed with a Tier 2 consisting of Primary Mental Health Workers with a responsibility for training and a consultation service for Tier 1 practitioners (Eaton, 2005). This LA was one of the pathfinder areas for the Sure Start programme and by 2009 eleven children’s centres had been opened across the town. Quality Protects was linked to training within the children’s social care department and two officers within the education department were appointed to try to develop links around looked after children to improve access to and achievement within education. This developed over time into The Virtual School led by an educational psychologist. The graduated response with the SEN Code of practice led to training and support for SENCos and a new funding
system with delegated funding for high incidence needs along with advisory teaching services to support schools and children.

In 2004 the decision was taken to move early to an integrated Children and Young People’s Department (education and child social care) with a Director of Children’s Services and a Lead Member in the council. This also led to the early emergence of a Children’s Trust and the new Local Children Safeguarding Board including the early appointment of an independent Chair. Children and Young People’s Plans were produced in 2006 and again in 2009 with priorities based on the five ECM outcomes. Included in the priorities in both plans was a focus on the emotional wellbeing of children and young people. The Children and Young People Plan (2009) emphasises the importance of the mental health agenda in the priorities:

“All children and young people who have mental health problems have access to timely, integrated, high quality assessment, treatment and support” (p. 18)

and the importance of practitioners working together:

“Workers will feel comfortable working across boundaries for the benefit of the child and young person” (p 45)

In 2006 the LA became one of the pilots for the Budget Holding Lead Professional (BHLP) project, which was given the name Bxxxxxx Early Action for Change (BEACH) (Livesley et al., 2008) . Along with other North West LAs it became an early adopter of ContactPoint. A Change for Children team was created to lead on the delivery and training for CAF, BHLP and ContactPoint. This process followed the approach recommended by Brandon et al. (2006a) which was a top down formal approach with some key ingredients: a small pilot with a quick implementation of both the CAF and Lead Professional (LP), clear guidance, raising awareness sessions across the whole geographical area, multi-agency training and IT in place. In all respects this describes the roll out in this LA except all agencies did not and still do not share an IT system.

In addition new front line teams using the Think Family approach were developed (DCSF, 2010). Building Schools for the Future was seen as an ideal way to improve buildings, develop the extended school concept and facilitate the development of special educational needs provision. An Assistant Director was appointed, who is
jointly funded by the NHS and LA and who was the early strategic lead of this team but was then moved into a new role due to restructuring of the department when adult services were added to the portfolio held by the Executive Director of Children’s Services 2010.

Following the formation of the coalition government in May 2010 there were significant impacts in the local area. The Building Schools for Future plans had to be shelved. Posts within the team became vulnerable and cuts to the budget were initiated.

6.2. Emotional Wellbeing in Schools Team Context

This team is both a multi-agency team as the practitioners in the team are employed by two different agencies (the Local Authority and the local NHS Primary Care Trust) and multi-disciplinary as the practitioners come from a variety of different disciplines e.g. psychology, education, social work, mental health and clinical psychology. This team is on the front line delivering a service directly to children, families and schools.

The team has in place many of the facilitators summarised above including: joint aims which are the five ECM outcomes and the aim to improve the emotional wellbeing of children and young people in a particular cluster of schools which is an aim shared by the link staff in the schools; joint assessment tool which is the Common Assessment Framework and is used as the starting point for every assessment in the team; a shared IT system to record case work which this LA has had a shared database (Education Management Systems, Capita) between schools and the education wing of children’s services for more than ten years. They have done joint training together on specific models such as solution focused approaches and understanding mental health through the risk and resiliency model. Most members of the team are co-located with a few exceptions who are based in schools. However those people who are based in schools can go to meet with their colleagues in the joint office. Each school has an identified link worker and each family has an identified lead practitioner. This team are a budget holding team with some discretion over commissioning other services and goods. Both the national project and the local bid have clear aims. There is a clear shared strategy for this team. There is also an Assistant Director who sits within the NHS and the LA and
who chaired the strategic group. The funding for this project is from central
government and locally there is a high level of agreement between the LA and the
NHS about its use. The cluster schools were included in a consultation at an early
stage and are represented in the operational and strategic groups.

6.3. Participants: Description of Team Members interviewed

The information below was extracted from the interviews and checked with the
Interviewees. The letters in brackets are the codes attached to the extracts given in
the result chapters.

Team Manager (B)

She trained as a teacher and worked as a classroom teacher. She was a special
constable for ten years which influenced her move from teaching and into an
attendance post in a school working with the transient population. Subsequently she
worked as a pupil welfare officer and then became the manager of the Behaviour
Education Support Team (BEST) the precursor to the Inclusion Support Team (IST)
which then became the Emotional Wellbeing in Schools Team (EWIST).

Family School Liaison (O)

Her original professional background was in the business world. Her route into this
team was via career moves into the voluntary sector and housing and then into
BEST (a multidisciplinary team which was a forerunner to this team), which
reformed as IST and is now EWIST. She identifies more with education than either
health or social care. Her role is a family/school liaison worker (which has its roots in
BEST and IST) and as a link worker between EWIST and the schools.

Social Worker (L)

She is a qualified social worker. She has worked in the social care sector since
1982 and she has been a qualified social worker since 1994. She joined EWIST
when it first formed.
Specialist Senior Educational Psychologist (A)

He trained and worked as a teacher. He then retrained as an educational psychologist. He also trained as a psychotherapist and he believes this puts a different slant on the way he does his work. He is registered with the Health Professionals Council and is a member of British Psychological Society. He has been part of a multi-disciplinary/agency team since he started in this LA and before. He had only recently (at time of interview - two terms) become part of EWIST.

Primary Care Mental Health Specialist (K)

She trained as an adult mental health nurse and worked as an adult mental health worker. She is registered with the Nursing and Midwifery Council and its ethical framework influences how she works. She started to work in the Team just doing one-to-one work with children and then became a full time member of the team. She is based in a different building from the rest of those interviewed.

Behaviour Advisory Teacher (P)

She is a qualified teacher and has worked as a classroom teacher. She started to work in an advisory teacher role when she joined the precursor to EWIST.

Family Support Worker (Parenting) (C)

She trained and worked as a nursery nurse and most recently as an occupational therapist. She is registered with the Health Professionals Council and its values and ethical framework are an influence in this work. She worked in a Sure Start setting. She joined EWIST when it first formed.

In the table below I have placed the interviewees (identified by the code letters) into a (same or different) box compared to the others under the features: employer, location, discipline and role. This allows a comparison between the seven of them across those features. Six have the same employer. Six are located in the same office. All have different roles and all come from different disciplines. In addition there is a summary of other features.
- One team leader
- Common tools
- Common models of understanding
- Regular team meetings
- Joint training
- Different supervisors

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<th>Same Employer</th>
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Table 2: Case Study EWIST Summary of features

Just prior to the start of the data collection a clinical psychologist had become part of the team for the first time but too late to be included in the research and a change in the educational psychology personnel had taken place. Two out of three were reassigned and a new member joined. The educational psychologist is the only member of those interviewed who has a different role as a member of another team in the LA (shown in italics).

However even with all these facilitators in place the formation of the team and the subsequent breakup since 2011 has taken place against a background of considerable change and uncertainty both locally and nationally as discussed in Chapters 2 and 10.
7. **Research Question 1: Results and Discussion**
What is the process of decision making around the choice of intervention for individual children?

7.1. **Introduction**
In this section I will offer my findings in the form of models and thematic networks using quotes from the interviewees to illustrate the points. I will discuss these findings further in Chapter 10. The main aim in this chapter is to create a rich picture of the DMP in this particular team. Based on my analysis as described in Chapter 5, I developed several models to illustrate the decision making process. One important feature of decision making in this team is that they rarely if ever describe a clear line demarcating the end of the decision making and the beginning of an intervention.

Decision making continues throughout the intervention on many levels. The decision making process (DMP) can be represented at three different levels (Figure 10). The first level I have called the structural level and involves the meetings and people involved. The second level shows the main actions which take place as part of this DMP. The third represents the cognitive processes and the types of decisions. I shall describe and discuss each of these in more detail.

7.2. **Level 1 Decision Making Process Structural: Meetings and People**

![Figure 10: Decision Making Process Level 1](image-url)
Figure 11 shows the most typical DMP in this team. The Common Assessment Framework (CAF) process is shown at the centre as the CAF form and the action plan are used as standard in the team and in only a very few cases is it not used. Figures 12 and 13 illustrate two atypical examples, which I will discuss later. The key meetings are the link meeting, the cluster meeting and the BEACh planning and
review meetings. Membership of the meetings is shown (people are represented by circles). The thickness of the lines shows the strongest relationship between people and the meetings, that is those who attend regularly or around a particular child. The arrows represent the lines of communication between meetings.

### 7.2.1. Common Assessment Framework Process

The CAF process is shown in the centre quite deliberately. A decision was made at the start of the TaMHS project in this LA that the CAF would be used as the main way of gathering information and provide the concept of an action plan, and this would be the process followed by all. This was in line with the practice as it had existed in the team which predated EWIST and for a while ran in parallel with the EWIST way of working. The red arrow shows the flow of information between the meetings and the completion of the CAF forms. I shall discuss the CAF in more detail in the DMP Actions section 7.3.3.1.

### 7.2.2. Link Meeting

The link meeting is the regular weekly or fortnightly meeting which takes place in a school. Membership consists of the named person from school (the school representative) and the EWIST named link worker with that school. Sometimes two EWIST team members attend. The aim is to build a working relationship between the school and EWIST.

> We have a system of link meetings whereby each cluster has a responsibility for five schools. Those five schools are shared out amongst the cluster as to who is going to attend the link meetings and generally the same person for each of the schools so they can build relationships with that school. (L1)

In one primary school and in all three secondary schools there are people from other agencies at the meeting.

> It's a multi agency meeting. The police are present at the meeting young carers somebody from Sure Start. There are a lot of professionals around the table. A child is discussed, everybody usually gives their opinion maybe that they can offer a service or they've heard of a service that may help. No decision is actually made at that point. (K1)
It is in the link meeting that a concern about a child is first raised with EWIST. Link workers with different professional backgrounds attend different link meetings and as the quote below acknowledges this difference may result in differing responses to similar cases considered:

\[
\text{So initially the first point of decision making takes place with the way the school describe those concerns to the link worker who represents the team at that point. They will listen and either ask some interesting questions about what's been done, what's not been done, how are they managing certain things. So collecting as much information as they can. It might be that within their either professional role or link worker role they can add something helpful into the basket at that point. (B1)}
\]

The decision to have everyone take a turn as a link worker was a pragmatic one:

\[
\text{When we first set up I seem to recollect that we had a conversation about as a team because one person going into every single cluster, every single school would just be a lot for them to do as well as managing a caseload. (L1)}
\]

However when two workers attend the meeting and one is a Primary Care Mental Health Specialist (PCMHS) sometimes this can result in decisions being made at the link meeting.

\[
\text{Xxx is also the link worker at named school with me so we go together so sometimes decisions are made at the link meeting. (O2)}
\]

This happens only when the PCMHS decides to do the work themselves. Quite explicitly the PCMHS I interviewed said

\[
\text{Yes I'm always careful not to make a decision although you might have something in your head and you might have your own ideas. I'm always careful not to say anything at that first meeting because you can't really make promises on behalf of everybody else in the team. (K1)}
\]

She relates this because she believes that this feature has helped to build up trust in each other. Occasionally a decision would be made to progress the work through gathering further information without reference to the cluster meeting and without a commitment for any intervention to be undertaken if it would involve a different team member. Sometimes additionally schools are advised to access another service or to gather more information.

\textbf{7.2.3. Cluster Meeting}

The concern is then taken back to the cluster meeting. The cluster is the group of five schools: one secondary and four primary schools. The same members of
EWIST - a group of five practitioners from five disciplines - attend the one cluster meeting. Some of them work across two clusters and they try to attend both meetings. This can happen when team members are off on sick leave. The cluster meeting take place weekly but when the school year advances and the number of children on the caseload increases the meetings are split and schools are discussed fortnightly. All five practitioners contribute to the meeting. One takes on the role of keeping the spreadsheet up to date, which I shall discuss later under actions. A discussion takes place about each child raised at the link meeting, about those currently worked with and up to closure. Sometimes this group decides that the case is not appropriate for them and the link worker will go back to the link meeting with this decision.

So we'd bring that back to the cluster group and we'd discuss the child and the situation. Then somebody else would say actually no that's not really appropriate for us. So there are times when it's not always appropriate so we would go back to school with that.  (O1)

It is at the cluster meeting that the five different professional backgrounds can contribute to the discussion.

..and then we take that information and we come back to our cluster meeting and that's where all the different people from our cluster - so there'll be somebody from health there obviously and somebody from education and we would discuss the case. And then it's kind of like a joint decision making process as to what we're probably going to offer for that family. (C1)

It's better to be discussed as a team because sometimes where I would possibly make that initial response there's other people from different. There's social work, behaviour advisory teacher and so on who can come up with, formulate a plan basically. And then decide who is best to deal with it and it usually involves a home visit first of all. (K1)

At the one cluster meeting I observed after all my interviews it operated as described by all five interviewees who were part of a cluster meeting. I did not examine the roles taken within the cluster meeting. The Specialist Senior Educational Psychologist (SSEP) and the Clinical Psychologist are not part of this meeting. They would be consulted by someone who had attended this meeting.
7.2.4. Two Atypical Examples

Figure 12 shows the process when the SSEP was involved in direct work with a child.

In this example one member of the cluster meeting consulted with the SSEP and on
the basis of this discussion one outcome was that the SSEP made an individual
decision that there was a piece of work that he could contribute. In the example
described he decided to assess another aspect of the child’s functioning and take
this information back to a meeting in school involving the school and parents.

Figure 13: Decision Making Process Structural Meetings and People (C)
Figure 13 illustrates another variation from the most common structural process which occurred on an occasion when the Behaviour Advisory Teacher (BAT) was involved in a piece of work purely in school and when there was no direct involvement with the parents. In this example the child in question was in care and another service was delivering family support. In my discussion with the team manager she thought this diagram could illustrate the process if one practitioner or only one agency was involved with the child and family.

7.2.5. Advantages of the Cluster Meeting

All of those I interviewed who are members of a cluster meeting spoke highly about it and made two significant points. The relief they felt at sharing decisions and not having to make a decision on one’s own (Quotes 1 and 2) and the added perspectives given to the discussion by the attendance at the meeting of five professional backgrounds (Quotes 3, 4, 5 and 6).

1.  I – Yes very different. It’s actually quite weird to go back to how we used to work as IST in that way as its all more on your shoulders
   HP – Is that a big difference for you between the two processes?
   I – Yes a very big difference because also you don’t have the same people to make decisions with. You’re making them on your own really so there is a big difference. (O1)

She expressed this in even stronger terms when she said:

2.  I – It’s taken the burden off me making all the decisions as a link worker. (O1)

It is clear here that having a mix of disciplines working together in a supportive way relieves some of the emotional impact and reassures practitioners that their decisions are more likely to be the correct ones. The interviewees communicated to the effect that different professional perspectives add clarity to the process of understanding a child’s needs and what to do next.

3.  Its different looking at it from a health perspective than from an educational background. Xxx has a different idea to what I have and then we’ve got social care. So looking at it with the different backgrounds always makes it a lot clearer. (K1)

4.  The more complex cases come when we’ve got safeguarding concerns definitely which is where we’ve really got the benefit of our social worker in the team. The mental health element as well even though some mental health issues are easier to say yes
that's very clear, but it's very murky isn't it? What is it? When does it become a problem? When does it actually move from effective stuff that's been put in place around the child to being the child that's got the issues for themselves? So those we have a discussion about it more. (P1)

5. I – It's helped me be clear bigger picture definitely and I like it HP - Bigger picture about a child so the causes of, the ways of understanding?
   I - Yes (P1)

6. I - Yes I’d say so because this is a wider team we have more agencies than we perhaps had when I worked for Sure Start. So it's kind of moved up a level and I think it works really well.
   HP – So moved up a level in the sense of giving you more?
   I – Yes more a better range probably of professionals within a team and a bit more in-depth understanding (C1)

They also talked about gaining more knowledge about systems and procedures and the language used by different professions.

I - Being in this team has definitely improved my knowledge I'd say of the social care system because we have our social workers here. Much better understanding of thresholds and things like that because I've got a social worker sat next to me, so it's so easy to pick it up. You feel like as you go along and certainly my knowledge of CAHMS was pretty basic I'd say before I came I came here. How it worked the different tiers and which were appropriate to be referred to specialists definitely. (C1)

Other team members celebrate that the social worker and PCMHS understand the other territory sufficiently to open the way or to make a decision about the appropriateness of a referral and to negotiate the referral. This trust and understanding has, they acknowledged, taken time to achieve and has resulted from the time spent in weekly meetings as well as sharing time in the office and training.

I think other people probably accept that and I think that is because we have been working together and we know each other now and so there has been some professional trust built up. (L1)

7.2.6. Time taken in CM

One concern expressed both by the interviewees and in the team feedback is the time taken in the cluster meetings.
The time constraints re CMs - yes they are valuable meetings but almost too long to manage alongside managing large case loads need to refine possibly (Team feedback Unknown)

In the observation of the cluster meeting they discussed thirty nine children in two hours and forty five minutes (on average 4 minutes per child). They only managed to cover two schools out of five. It was a very intensive meeting and they have these once a week.

7.2.7. Joint interventions

A number of interviewees also value the opportunity of being part of a team and being able to conduct interventions jointly.

HP –Do you think having two people do those two different strands of work was important?
I – I think so yes. Yes I do. I think for the relationship side of it. I think it would be quite difficult probably especially in the early days to have gone into school and done the work and expected the child to open up and feel they could trust you perhaps knowing you were still also seeing Mum around behaviour issues at home. (C1)

7.2.8. Advantages of Consultation with an Educational Psychologist and Clinical Psychologist

Although the Educational Psychologist (G) and Clinical Psychologist (H) are not part of the cluster meeting all team members can consult with them. This is mentioned by a number of the others as a positive process (Quotes 7 and 8).

7. It's helped in being able to understand some of the things that are going on with families. It's helped me focus some of the work that I need to do. In particular a case I'm working on now there's a young man who's having great difficulty attending school. ... The EP that I've spoken to has given me some ways of working with him and also some anxiety scales to do with him to see what's really going on and that's been very helpful. (L1)

8. I – and that's often when it's highlighted that as a team this would be a really good one to take to clinical psychology, but also that kind of feeling of being stuck with something you know and just think I don't know where to go from this point that I'm at. (C2)
7.2.9. **BEACH Planning Meeting and Review Meetings**

These are a series of meetings which take place to initiate an intervention or package of interventions and to review them over time. Different members of the team used different terminology for these meetings but all were referring to the same type of meeting. At the planning meeting the parent, sometimes the child or young person, the school representative (sometimes more than one) and the EWIST worker(s) agree what are the areas of need and what actions to take. Desired outcomes are agreed. This is all fed into the CAF process. The review meetings, which usually involved the same people, are usually planned at the first meeting. The decisions of this meeting are taken to the cluster meeting and recorded.

The interactions between these three types of meetings (link meeting, cluster meeting and planning/review meetings) are based on the flow of information conveyed by the members of the cluster meeting who also attend the other two meetings. It is not helpful to view these three meetings as fixed in terms of their place in a decision making sequential flow. As described below the BEACH Planning meeting and the reviews can take precedence over the Cluster Meeting. The CM would not overrule a decision about the next step in an intervention or a package of interventions.

*HP - But if there was a disagreement between maybe a decision made at the CAF meeting and the cluster meeting? Has that ever arisen?*

*I - No it hasn't actually. Usually when we've had a CAF meeting those decisions are brought back in the form of an action plan to our cluster meetings and I would go through that action plan so the changes could be noted.*

*HP – Which would you say took precedence? Is it the CAF meeting that would take precedence?*

*I – Yes. (C2)*

The dynamic is more subtle. The CM usually decides who is going to deliver an intervention before it starts and this to some extent determines the overarching approach.

7.2.10. **Parents involved in the decision making**

Another advantage of the BEACH and review meetings is described in the following quote in which the interviewee referred to CAF meetings.
I think that families have taken to CAF meetings because they are included and they feel that they are being included in the decision making. (L1)

In the opinion of the interviewees, families feel part of the decision making and it is interesting to note in the quotes from the team members the importance placed on the active involvement of parents and children in the DMP and how their views are taken into account. I discuss this further in Chapter 9 and 10. Obviously I did not explore the views of the families in my research. The one reference to a poorly run meeting in the interviews refers to one taking place in a school.

I went to one. I was gob smacked actually. This was a very inexperienced school in delivering it (and they were) really abrupt with the parents and ended up with the parents crying because it was done in such a poor way. The situation didn't need to lead to that. It was handled really badly. Fortunately we managed to turn it around but that's just an example. Granted this particular school has since improved and got more experience of it and they've got better. What's interesting is we at EWIST don't always take over this role. Schools are starting to complete CAF's more and more themselves which is really good, but I think that we are able to do a lot of good modelling, good practice for a lot of schools. Other schools are really good at it anyway. (P1)

However as exemplified in the quote above this is seen as something to improve and part of the role of the team members to help school staff develop their skills with the CAF process and involving parents effectively.

As this LA was part of the Budget Holding Lead Professional Pilot this team had a budget they could access via their team manager and they certainly mention occasions when the budget is accessed to buy services or goods for families. I did not explore whether or not the families felt as fully involved with this aspect of decision making. However the team members certainly recount occasions when the direction of the intervention was guided by the parent’s views. I discuss this further in Chapter 9 and 10.
7.3. **Level 2 Decision Making Process - Actions: Gathering Information and Recording Information and Decisions**

![Diagram of Decision Making Process Level 2](image)

**Figure 14: Decision Making Process Level 2**

### 7.3.1. Introduction

I have divided the actions up into two networks: gathering information and recording. I have produced diagrams to illustrate these two actions separately; the second one (Figure 16) “recording” shows the methods of storage of the information, the actions and the decisions.

### 7.3.2. Level 2 DMP Actions: Gathering Information

Figure 15 illustrates the network for the action of gathering information related to the Decision Making Process.
The types of information mentioned by the interviewees includes biographical data; opinions expressed by those directly involved such as the child, class teacher and parents, but also opinions expressed by others about the child or family; teacher assessments; observations by team members; and psychometric tests, defined as those tests which have been standardised across populations. Decisions about what information to gather are linked to what models of understanding the team members hold. However, as the CAF process is followed, the CAF form is used to record information. This determines the biographical data and the areas of the child’s life about which information is gathered. I discuss the form in more detail in section 7.3.3.1.
The process of gathering information, as described in the interviews and as I observed in the cluster meeting I attended, is an ongoing process. It does not take place at the beginning and at the end of an intervention but continuously throughout the intervention stage. New information can and does result in changes to the intervention. There are frequent mentions in the cluster meeting of events which had been reported happening within families who are currently being supported and as a result of this information decisions are made to visit or offer a further parenting course for parents or an intervention for the child.

Biographical information includes such details as name, address, family members, developmental history and family history. Much of the information gathered is subjective, in effect someone’s opinion or their version of events including for example the parent’s version of the child’s developmental history or the class teacher’s version of behaviour in class. However team members also aim to gather information in other ways as well. They do observations in class, they talk to the child and find out their views and they consult with the school about the history in school. Information gathered is neither neutral nor absolute.

7.3.3. **Level 2 DMP Actions: Recording**

Figure 16 illustrates the theme network for the action of recording within the team. There are three aspects: recording information, recording decisions and then recording ongoing contact with a case.
As we discussed an earlier version of this diagram we realised that sometimes information does not
get recorded anywhere but is held in the team members’ heads. Of course the guiding beliefs might never be recorded.

7.3.3.1. CAF Form

The main recording tool is the Common Assessment Framework Form (downloadable from: [http://www.education.gov.uk/childrenandyoungpeople/strategy/integratedworking/caf/a0068970/the-pre-caf-and-full-caf-forms](http://www.education.gov.uk/childrenandyoungpeople/strategy/integratedworking/caf/a0068970/the-pre-caf-and-full-caf-forms)). As I reported above, the decision when setting up this team was that the CAF process would be central. This had already been the case prior to EWIST as the manager of the team was an early adopter within the LA of this way of working and had been instrumental in encouraging schools to use the CAF as a tool for collecting information and recording what actions to take with the family to help the child. Therefore in the early negotiations with schools about this project and in the project application the CAF was part of the original description of the team processes. In addition there is an expectation that schools will engage with the process by using the CAF before the involvement of EWIST.

I – So if we were going to take on a full piece of work we would have had an expectation the school would have initiated or be about to initiate a CAF.

HP – But for the initial discussion it can be a pre CAF?

I – It would be a pre CAF or even just an enquiry where they just want a quick phone call. (B1)

All of the team members who are part of the cluster meeting spoke positively about the CAF form.

I like documentation like that. When someone says to me we’ve got a child here for you to see I always say is there a pre CAF? Because I work across two clusters because of the shortfall in the staff, so sometimes it’s a case of could you just come and see this child? I like something in black and white something that I can refer back to. So I would start with a pre CAF and then even better if there’s a CAF. Really coming from a health background we’re used to working with the assessment forms and reading through and adding as we go along and up to date information. (K1)

However there are some provisos about the CAF form. These include some doubts as to the description of it as an assessment tool. In the quote below from the manager she suggested that in fact it is a tool to collect information and that there are other assessments which direct the interventions.
I don't think it's an assessment I think and this is a personal opinion this I think it's fab for collecting common information it's a good common information form it should be called a CIF not a CAF. Then from there you need true assessment in particular relevant fields. (B1)

However as a way to collect information its underlying model fits with one of the main models of understanding employed within the team namely “Risk and Resilience” which is discussed further in the answer to Research Question 2 (Chapter 8).

I find it really helpful. I feel that it’s really really integrated into how this team work so we just naturally take that out. When I go out to meet a family for the first time I would take a CAF form with me regardless of whether I thought that child would probably need a CAF to be raised for them and I would use it anyway as an assessment tool because it’s just such a good way of recording the information and making sure that I’ve hit on all the points. (C1)

But the quality of information gathered via the CAF can be an issue for the team.

I think when you learn to use a CAF and you do it in your own style and I think it’s a massive ask of people to ask people to do that and we don’t have any in depth training on it so that’s probably a weakness and a gap. They all have to do the CAF training so they all get trained to do that but I’m not sure from being a CAF trainer that that leaves you fully equipped to actually go out there and complete high standard assessments. I think they learn by going along with other colleagues but then at the end of the day they have to create their own style and I think you can get familiar with the CAF you can get familiar with the questions. But I think for me the skill to it, actually knowing your own style and how you are going to ask those questions. Also being alert to your listening and listening to what the client is telling you because you need to then know what to ask next and for that information to be relevant. I think what you see is a difference of depth of case going on people who don’t hear the things that you are alert to; you might not follow that up or ask another question.... For instance it might be you might come from social work background then you might ask more questions your assessment might be more in depth. (B1)

There is a theme that the data is lacking in some way at the start.

I think we start off with fairly impoverished information anyway and that very often a lot of what the intervention is about is gaining quality information upon which to make a decision. (A1)

The information gathered through using the CAF is dependent on both the skill of the person asking the question, the willingness of those being questioned to give the information or sometimes, not necessarily the willingness, but the acceptance
that this information is relevant or necessary. The following two quotes demonstrate this with parents.

_Sometimes you can gauge when parents might be a bit unforthcoming so you might not do it all on the first session if you think they’re not ready to answer. I’ve had one recently where I filled in the CAF fine and she did not tell me that much information. A few weeks ago I was on the home visit and she said oh and this and this and this and I was like I don’t know and she said yes I told you before and I was like no you haven’t but she obviously thought she’d already told me stuff so you know things crop up._ (O1)

_In terms of the document to use and as information to feed into some of our work it depends on how it’s completed would depend on how valuable that is. One thing that is really interesting is the more that I’m having involvement with CAF is it really depends on what the parents want to share. Some parents are very very open you know that but you also know that some parents really aren’t or for example you fill it in thinking you know all the information and then four or five weeks down the line something else comes along and you think goodness me this is such a significant huge thing that wasn’t on the CAF._ (P1)

The staff members in school who provide information to EWIST are prone to the same issue. In one instance the school had not shared, although they should have known it was relevant, that the Statutory Assessment Process had started with a particular child. However as might be expected the quality of information varies between schools and team members are aware of their role in modelling good quality completion of the CAF form.

_What’s interesting is we at EWIST don’t always take over this role schools are starting to complete CAF’s more and more themselves which is really good, but I think that we are able to do a lot of good modelling, good practice for a lot of schools._ (P1)

_It’s interesting because some people will spend a long time on it. You can see that they take it really seriously and they want to gather as much information but I think that some people will try and make it as quick a process as possible. I can understand why they would because it can be lengthy and for the parents as well to be sitting for hours on end but that’s where sometimes things are missed._ (P1)

These views are confirmed via the feedback from the team as a whole.

_Difficult to trust CAFs completed by others as they have their own biases and can write the CAFs based on own opinions as to what they feel is needed._ (Feedback from member of team – unknown)
Quality of information on CAFs variable based on how person is completing it has been trained in assessment and how they value it too – a paper exercise or a useful tool? (Feedback from member of team – unknown)

CAFs completed by other staff (e.g. school) varies – some are excellent, some are far from excellent – sometimes requiring EWIST to home visit to gather more information before identifying best intervention (Feedback from member of team – unknown)

7.3.3.2. Spreadsheet
The spreadsheet is the ongoing record of contact with the child. This is filled in each cluster meeting as team members report back on the work they have completed. I have not examined this record closely as there would be details about individual children and their families and that was not part of the original research plan. However having observed a cluster meeting it was clearly being used to check what had been agreed previously and to record the actions planned. This record could be used to hold team members accountable for their actions.

7.3.3.3. Education Management System (EMS) Capita
This data management system has been used within the LA since the early days of becoming a unitary authority in 1998. It is linked to the schools’ data management system and it has evolved so that there is a weekly download between schools and the central database of all children on roll in schools. It also contains the details of all children arriving into the authority, even before they are allocated a school place if the authority becomes aware of their presence in the authority. These systems have developed as a result of the high levels of transience into, out of and within the authority and with the intention to avoid losing children from the school system, identified nationally as a problem (DCSF, 2009). The EMS case file system is used to keep records of ongoing visits and actions and is visible to everyone on the team and therefore allows the sharing of information easily as long as people use it to record their actions.

7.3.3.4. Decisions: Action Plan
The type of actions and outcomes recorded in the action plan vary. Some are easily measured but some are not, for example an outcome could be “better relationship”, which is hard to measure.
I think because we use the CAF we always have a very clear view of where we want to be. The action plan might say something about working with the child and the outcome would be better relationship with somebody or attend school on a regular basis or whatever. (L1)

HP – We mentioned that was having an outcome for something like better relationship which is hard to measure. Are there some actions where it’s easier to see you’ve completed?
I – Yes absolutely. I might be referring to another agency so I would put on my action plan, I would do that within a week so then you can see you can tick it off. (C1)

7.4. Level 3 Decision Making Process: Cognitive Processes

7.4.1. Introduction

Figures 18 and 19 illustrate the aspects of the DMP which are cognitive in the sense of relating to cognition (Oxford Dictionary online) which is defined as ‘the mental action or process of acquiring knowledge and understanding through thought, experience and the senses.’ As discussed above there are limitations to accessing retrospectively peoples’ thought processes about their decisions. One reason is that people tend to rationalise to provide an explanation for what they did post hoc. I
took precautions in the interviews not to ask ‘why’ to reduce the chance that the interviewees would start to construct their narratives around the reasons for taking a particular action or making a particular choice. I wanted to gather descriptions of the process and from those infer what cognitive processes were taking place.

7.4.2. Decision Making Process: Types of Decisions

Figure 18 illustrates the most common types of decisions which arose in the descriptions of the process. However these are my interpretations from the interviews, they are rarely explicitly described as ‘this is the decision we had to make’.

At the initial stage of each description and very obviously in the observation of the cluster meeting whenever a new case is raised by the school there is an exploration of both safeguarding issues and health issues.

*I might be given a CAF to complete with a family where there is some queries as to whether or not there might be child protection issues but nothing concrete. So whilst I am doing the CAF I can have my social work head on and look to see whether anything is going on. Structure the CAF questions as though they are an initial assessment.* (L1)

For team members having a social worker as part of their cluster meeting means that they can check concerns with them. The same was said in relation to the idea that emotional wellbeing issues being raised might be more serious and might require a more specialist approach.

*Is this child depressed? xxx went in to do some work to see whether this is just the way this child was or is there anything underlying that’s going on. Those situations it’s good to have that mental health expert.* (O1)

Both of these concerns are revisited as the cases unfold and throughout the interventions especially if new information about, for example, an incidence of domestic violence is reported.
The decision about who should collect the information is sometimes based on the idea that the best person to do that would be the one most likely to carry out the intervention.

*We'd make a choice of who'd probably be the most relevant person and that helps consistency for the family really. So if it's sounding from school like most the child's fine in school but got lots of concerns at home then it's probably me that would go out and do that first home visit because it's likely to be more issues at home.* (C1)
However this is not then fixed as the interviewees describe sometimes uncovering further information which then leads to someone else delivering an intervention. Sometimes there is a level of uncertainty about what to do.

*But there are times where you just think oh I don't know what to do so you have to you try something and hope that it works.* (O2)

The ongoing monitoring of every case which takes place within the cluster meeting allows a level of quality control, supervisory advice and a safety net in case an individual practitioner does not know what to do next, has not carried out an agreed action or has not recognised the need to change direction.

The decision to close a case is based on the opinions from the parents, child and school staff members gathered by the key practitioner working with the child. This does not usually involve the Strengths and Difficulties Questionnaire (SDQ) data. This is gathered before an intervention and usually after there has been a decision to close a case. In the CM there was some discussion about gathering in SDQs from teachers and parents for cases which were in the process of being closed. This was proving very time consuming.

7.4.3. **Decision Making Process: Cognitive Processes**

Underlying those types of decisions within individual interviewees' thought processes there appear to be commonalities. Figure 19 captures my interpretations of the cognitive processes for which there appear to be examples in the text. This is an area of theme identification which relied heavily on the literature review of decision making. I searched explicitly for examples of intuition, pattern recognition and formulations. The other themes arose from the text. I have produced a codebook for these themes shown in Appendix 9.

The interviewees often use the words “this looks like” or “I felt that” when they describe the beginning stages of the process.

*I suppose because you’re the one the goes into the school and collects that information, you do feel that you have more sense of what is going on for that family.* (L1)

*Normally you’ll discuss what the issues are and people go alright that’s my kind of. Oh yes xxxx will say that mum could need some parenting*
there so that would be me and then xxxx looks more mental health, there might be something for me. So it is very much we can kind of everybody sees their kind of role really within it. I think we do it quite well really identifying who's the best person to do this piece of work. (O1)

I am suggesting here that this is an indication of some type of intuition taking place. I am suggesting that either they are recognising patterns between cases or feelings are being triggered subconsciously by features in the cases.

The next step seems to be that they use some type of perspective to think about the case, though not necessarily articulated as such, which I discuss further in Chapter 8. They acknowledge other perspectives as I have discussed above and value the clarity they bring to the process, hence my use here of the image of a lens.

I suppose that's because I treat Psychology as a lens but don't feel it's the only lens. They might be equally true in their own way but part of the value of the multi-disciplinary team is to look through lots of lenses at the same time. (A1)

Following the use of a lens the DMP follows one of three paths. Some interviewees tended to simply restate the story of the child, which I have defined as “a list or narrative description of events or factors but no linking to causes or consequences or theory” and then recount the actions they have taken.

The one that I particularly have in mind is a nine year old girl and she was referred to us. That came from a referral from school within the school link meeting and was brought back to our cluster meeting and then we discussed this case and it was particularly felt from school that a lot of issues were at home. Possibly around parenting because there were a lot of behaviour problems coming out at home so therefore it was given to me as the parenting worker to go out and do that first initial contact with Mum. (C2)
Some interviewees analysed the story, which I have defined as "describes a sequence of events and factors and links to causes and consequences but no explicit linking to theory".

*I tend to take each one as it comes I think. For example this wasn't the case but other cases if I know that they've got a diagnosis of ADHD or there are questions around ADHD, I have different things in my mind that I know I'm looking for. But I don't have anything particular I'm just looking at what I'm seeing and the key things that I look for really are key triggers for the youngster and interactions between the youngsters and the adults in the room. That for me is my real priority and then I kind of work around that as well and looking at this I'm kind of picking the strategies that are being used in the classroom.* (P1)

The third pathway I have called formulation and I have used the British Psychological Society Clinical Psychology definition:
developing formulations of presenting problems or situations which integrate information from assessments within a coherent framework, that draws upon psychological theory and evidence and which incorporates interpersonal, societal, cultural and biological factors. ((BPS, 2011)

But the upshot of it was that cognitively he had very very low on the WISC a very very low working memory score and he himself was saying things like he doesn't always remember things like instructions that member of staff have said to him and for any kind of lengthy expositions sort of an introduction to what our topic is going to be he has very little chance of remembering key bits of that. So I did a cognitive assessment first time around because there had been some question about learning difficulties. I thought it was probably as well and then when in school had done it to actually look at the attainments as well. So the second time I went back looked at his attainments - what have we got there. (A2)

Most interviewees showed examples of all three at times in their narratives.

7.4.4. Value of different perspectives

It is intriguing that the description in the interviews of the value of different perspectives as something they have learnt to appreciate over time and which is continuing to develop.

I think we are getting towards a shared language. When you throw a whole load of different professionals in a room together then at first it takes time doesn’t it for you to actually understand what’s going on with everybody else but I think we are getting there. I don’t think we are there yet. But I think in general we have a shared understanding of what young people are going through. (L1)

The value placed by the interviewees of this team on the expertise brought to this team by different disciplines is understandable given the complexity of the cases. I discuss this further in Chapters 8 and 10.

7.5. Conclusions

Research Question 1: What is the process of decision making around the choice of intervention for individual children?

I have used several diagrams to illustrate the process of decision making in this team. I have described the meetings, people and paper work involved. I have speculated about the underlying cognitive processes involved. The DMP is a complex, iterative process which is facilitated by a predetermined organisational
structure and continues throughout the assessment and intervention stages. The CAF form and process are central. Decisions are usually shared and the views of different disciplines are valued and utilised to make decisions. The involvement of school staff, parents and children in the process is welcomed, facilitated and valued. The interviewees feel that the process is equal and that all views are respected. There are clear indications that team members value different perspectives and it has taken time spent together in training, in the office, in cluster meetings and delivering intervention to build up trust and professional understanding. There are some indications that intuition is involved in the decision making, as well as a slower, more deductive and step by step process. In some but not all descriptions there are clear linkages between causal explanations, theoretical underpinnings and decisions made. In the next chapter I will discuss theoretical underpinnings and models of understanding in more detail.
8. **Research Question 2**

How do team members conceptualise the circumstances that children and families and schools experience and why do they use these conceptualisations?

8.1. **Introduction**

With this research question I intended to identify and explore what are the underlying models of understanding or theoretical underpinnings held by the interviewees. I did not want to lead them into giving me a named model by asking a direct question. I chose instead to ask a very open question in interview 1:

> *I have used the word circumstances in my research question – that children and families and schools experience – what word or phrase would be most commonly used by you and those you work with?*

I chose the word ‘circumstance’ as I decided that this was as neutral a term as possible. I could have used ‘problem, difficulty, or disorder’ but all of these have overtones related to different professional areas. In the interview I used this question to initiate the discussion and then if necessary followed this with some prompts. However I also analysed the text in both interview 1 and 2 looking for examples of models of understanding. In the second interview I examined the text both as they described the child and family and also when they described their interventions. In developing a thematic code for the interviews I was looking for examples of theories and or models defined as follows:

*Theory: a supposition or a system of ideas intended to explain something* (Oxford dictionary online)

*Model: A schematic description of a system, theory, or phenomenon that accounts for its known or inferred properties and may be used for further study of its character* (The free dictionary online)

In this sense, “model” is the application of an underlying theoretical position. For instance Triple P Parenting is a model based on social learning theory. At times the interviewees used a term which is linked to a theory or model:

> *I’d spent quite a while in our sessions using the CBT model and sort of challenging these negative thoughts she had about what parents thought about her and some sessions actually building up her resilience* (K2) (my emphasis)
However at other times the use of a theory or model was implicit. In this sense I am interested in their ‘informal practitioner theory, rather than what might be called formal academic research-based theory.’ (Moore, 2005: p.107) However in describing them here I have used the names of acknowledged models.

I note that three interviewees comment directly on the importance of knowing the theoretical underpinnings of their ideas. Firstly the team manager as a result of reflection within the interview comments that the team has not been explicit about the underlying theory in daily discussions and the possible advantage if throughout the team they were to be more explicit.

I – We haven’t got that right, but as you said that I did think then that I had a little light bulb moment. I thought that we don’t use the vocabulary as openly as risk and resilience when we are going through that process, but maybe if we did that would help us all commonly appreciate what we were building on. Whether it was working with the family maybe we could strengthen that. If that does work for the team maybe I don’t know maybe we could build on that maybe. (B1)

Again in the following quote the interviewee refers to a discussion within the team about the realisation that they do not think back to theory on a day to day basis.

And you don’t think back to the theory. It is funny, we were talking about this earlier, about academic theories and actual practice and it is wrong and we should think more about the theories that underpin what we are doing but we don’t always which is dreadful. (L1)

In the following extract it is possible to see the practitioner thinking through the process of trying to make sense of a child’s behaviour in the context of a risk and resilience type of approach, but without naming the model.

HP – So just in terms of your model of understanding children and what’s happening in their lives, do you have a kind of underlying model of understanding children in terms of causes and what guides you in terms of interventions and things?
I - I probably do
HP – This is a sticky one
I – This is where it is getting tough. I think I mean obviously when you have spoken to school and parents you have got a good picture of it. If they tell you everything you know exactly things that have happened to this child that could explain the way they are or it could be something else. •
HP – I mean basically what you are describing there your belief your model of understanding would be to say that a child’s behaviour can be caused by particular life events particular things going on?
I - Yes
HP - With life so risk and resiliency that sort of approach that kind of idea.
In the first round of data analysis I took my initial ideas back to the whole team as agreed for feedback. In my feedback to the team I suggested that there are two general underlying approaches for intervention namely solution focused and cognitive/behavioural and two general underlying models of understanding namely risk and resiliency and social learning (underlying Triple P). I suggested that between those I had interviewed there are differences in thinking which could be best categorised by placement along a single dimension with “environmental/life events” at one end and “within child/constitutional” at the other end (Figure 20). This dimension seems to underlie the thinking about both the understanding of the origin of the “problem” (causation) and in developing the intervention.

<table>
<thead>
<tr>
<th>Environmental (Life events)</th>
<th>Within-child (constitutional)</th>
</tr>
</thead>
</table>

Figure 20: Initial Interpretation of Model of Understanding

I also suggested that there is a belief that early intervention can prevent “problems” getting worse such as poor outcomes in adult life leading to mental disorder diagnosis or risky behaviour or addictions. The feedback from the team accepted that this had captured some elements of the models used. However as I completed the first analysis very quickly to fit into the team development timetable I was aware that I had not captured all the subtleties.

In my review of the interviews after the team feedback I recoded all the interviews and developed the thematic code shown in the codebook in Appendix 10. I then used the Matrix Coding Query facility in NVIVO to check for overlaps between the themes and I used these to further refine the themes and their definitions. In some examples the overlaps showed inappropriate coding of text and I therefore removed these segments of text from that theme. In other cases the overlaps showed that more than one model was being used within a piece of text. This matrix also helped me to develop the two sub themes described below as it highlighted the differences between overarching models of understanding such as risk and resilience and biopsychosocial and then component theories such as attachment theory. It also showed that a model could be used to plan and deliver an intervention separate
from the initial model of understanding. In the recoding of this area I sorted the themes under the overarching theme of Models of Understanding into two main subthemes in Figure 21. The subthemes are named Explanatory Models and Guiding Interventions. Some of the models fit into both subthemes. I then compared the themes extracted from the interviews with the notes taken during the observation of the cluster meeting to check for the use of these models in a real life situation. I also returned written feedback about their models to each of the interviewees.

8.2. Sub Theme 1: Explanatory Models
I have used the term explanatory to describe those models used to understand underlying causes or causal mechanisms and to explain how the current situation had developed. All interviewees use models which see the child within the systems in which they live. The child is always described along with their family, any life events seen as important and also their school situation. Within child factors are important as well and are described in a number of ways.
8.2.1. Risk and Resilience

The most frequently coded (57 references across all interviewees) explanatory model of understanding I have described as Risk and Resilience in the sense referred to within the TaMHS guidance for headteachers and commissioners (DCSF, 2008e) which includes a list of risk and resilience factors in relation to
mental health. The risk factors are those factors identified by research which have an adverse effect on mental health and resilience factors are those that if present or promoted can help to ameliorate or protect the child from mental health problems. The guidance divides the factors up into three sectors: in the child, in the family and in the community. They argue that the therapeutic approaches described in the document all address either or both risk and resilience factors. Only three of the interviewees when asked said they had read the TaMHS guidance document.

It was clear both in the interviews and in the observation of the cluster meeting that one of the first decisions that team members make is to check if there is information to suggest that a child is at risk from significant harm. There is also a review of other risk factors and resilience factors usually with reference to events which have happened in the past or which are currently happening. This model is then one of the main models for guiding interventions. The interventions are often directed towards reducing or preventing a risk factor or promoting a resilience factor.

Given that this project uses the CAF process and in particular the CAF form, this also encourages a risk and resilience approach to be taken. Although the CAF guidance does not use the language of resilience, the Common Assessment Framework form and approach were built on the same structure as the Framework of Assessment of Children in Need and their Families (DH 2000; Brandon et al., 2006a). The Framework of Assessment uses the language of needs and strengths and divides the Assessment into the three domains: Child’s Developmental Needs, Parenting Capacity and Family and Environmental Factors as does the guidance for the CAF (Children’s Workforce Development Council, 2007a, 2007b, 2009). There is a direct imperative not just to identify needs but also to identify strengths to be used as central to an intervention. In addition some of the team members in the early stages of the project received training which links supporting mental health with this model as a way to understand the child’s presentation and to decide how to support the child.

8.2.2. Analysing systems

In line with this is the use of systems analysis in the descriptive text (58 references across all interviewees.) All interviewees describe both the family environments and
the school environments when conceptualising the child’s circumstances. Then one of the two would become the main focus of an intervention. In most cases the family would be seen as causal both in terms of parenting styles and life events. In most cases the school environment would be seen as ameliorating a difficulty which had arisen through biological, constitutional problems, life events or from the family circumstances, but sometimes would be seen to make a problem worse. The school staff members are seen positively as part of the solution especially in primary schools.

I think they’re in the best position to help because they spend the majority of the time with that child particularly in primary schools. That one teacher spends a full day with that child majority of the time. High schools are a bit more difficult because there are the changes in the teachers. They could have as many as six seven teachers in a day. I think primary schools are in a fantastic position to actually do something and change something positive in that child’s life and I have seen that (K1)

8.2.3. Biopsychosocial and Medical Model

However in addition to risk and resilience as an approach I have coded some text to biopsychosocial model. I use a code which required the use of the terminology biological, social and/or psychological. Only one interviewee uses this terminology. He also uses systems analysis. Others may own biopsychosocial to describe their thinking but they do not explicitly use the terminology. However they all describe within child factors and descriptions of the child’s family and schools. I coded text to medical model when there is a more explicit reference to a diagnostic label and the implication that a medical solution might be needed. My identification of these models was, except in the instance of the use of the terminology, an interpretation of the language used and not an explicit declaration on the part of the interviewees. The choice of these labels instead of Risk and Resilience is based on the balance of the factors.

8.2.4. Within Child Factors

I have coded text to various within child factors under five headings. There are some factors which are seen as constitutional aspects of the child which are inherent and there from birth. These would include specifically cognitive factors such as short term memory problems and developmental conditions such as autism. Then there are some which could be seen as developing over time as a result of life
events and experiences, for example trauma (not just an event but something which has affected the child), self esteem and locus of control.

8.2.5. Personal Construct Psychology and Attachment Theory

There are two further theories which are named by interviewees specifically and used in their descriptions and these are Personal Construct Psychology and Attachment Theory. Personal Construct Psychology is named and clearly used by the Educational Psychologist, in part as a way of exploring with a young person their view of their difficulties. Attachment theory although not named in all coded texts is used as an explanation of a child’s current functioning and sometimes, as in the example in the codebook, it is used to explain a child to adults in the child’s life, even though it is not the guiding rationale behind the intervention which is more behavioural/social learning in orientation.

8.2.6. Behavioural Theory

Behavioural theory sat both as an explanatory model and also explicitly as a theory to guide interventions. Often in their analysis of the environments the interviewees used a behavioural analysis approach. Of course social learning theory is one of the underlying theories for Triple P (Sanders et al., 2003). In addition a cognitive behavioural analysis is used as an explanation and again to guide interventions.

8.2.7. Level of agreement

As I discussed before in the last chapter the interviewees celebrate the different perspectives brought to the team by different disciplines. However overwhelmingly there is a high level of agreement in the underlying models brought to bear on conceptualising the child’s circumstances.

8.2.8. Sub Theme 2: Guiding Interventions

Figure 22 shows the theme network for guiding interventions. There is a strong bias towards finding solutions and on building resilience rather than digging into causes or attaching labels to children or situations. Throughout all the interviews there is a
very strong pragmatic theme. Energy is directed towards keeping children safe and finding realistic solutions for whatever is the presenting issue.

Figure 22: Models of Understanding Guiding Interventions
Often, in the course of a description of a piece of work with a family, interventions from different models are described. I therefore use an eclectic code. In the example in the codebook the practitioner uses different approaches within one intervention. One interviewee uses the concept of Maslow’s Hierarchy in her thinking. I offered the term to name her description:

I - Yes but sometimes actually I go a step further back than that, where I would probably put in what I would call more family support work. So maybe I’m looking at the housing situations really unstable or something like that. That makes that family’s situation really quite vulnerable at the moment.
HP – So there’s an element in that correct me if I’m wrong but there’s an element of saying if the basics aren’t right for a family? No you explained it right this is just me putting it into this language. If this isn’t comfortable language then just say to me, but it sounds a little bit like Maslow’s hierarchy?
I - Yes I just going to say I was thinking then yes exactly. (C1)

This theme recurs in her second interview when she is describing in detail the course of the intervention with the family which started with early intervention and then develops into support for the future and more aspirational targets.

I – I think the family had become very isolated. So I think because they’d got into that very state of isolation, weren’t really communicating with school, I think that their relationship would have continued to deteriorate between Mum and the little girl and I think not having anybody to speak to or to sort of support to look to the future. I did quite a few practical things with her like finding information from college together and she certainly seemed to need that little kick start to get going. (C1)

In the first example this connects with a risk and resilience model and with the idea of reducing risks and in the second example there is an element of building resilience within the family via the mother’s educational development. She also links this to explicit goals in her descriptions as shown in the codebook. She also uses an explicit example of empowerment as did another interviewee who also uses two explicit references to the person centred approach.

I suppose it goes back to the non judgmental stuff I am here to help you it’s your family you know what you want. I am here to help you. (L2)
8.3. Conclusions

RQ 2: How do team members conceptualise the circumstances that children and families and schools experience and why do they use these conceptualisations?

There is a very high level of agreement in the way team members conceptualise the circumstances, even though they rarely name models as such. They generally use a risk and resilience model with a solution focused approach underlying interventions. The main joint training has been around those approaches. There is a strong pragmatic element to the narratives in the sense that the team members describe finding and adapting solutions whatever the circumstances and at all times keeping children safe and promoting their wellbeing. They recount ways of ensuring that parents are on board and involved.
9. **Research Question 3**

What influences the choice of interventions and why do the team members make particular choices of interventions?

9.1. **Introduction**

The findings for this question have to be understood in the context that the interviewees described a process in which the assessment phase and the intervention phase are not separate and distinct. Interventions are not usually offered as one-off packages. There is rarely a clear assessment phase followed by an intervention phase, instead the processes overlap and run into each other. One consequence of this is that instead of one decision point, an iterative process of gathering information is described. This extends into the development of a therapeutic relationship with child and family during which further decisions are made. There is in effect a DMP feedback loop. Figure 23 illustrates the thematic network showing the influences which were referred to during the second interview when the interviewees were describing their successful case. The codebook is shown in Appendix 11. However I have also included examples which were mentioned at other points in both interviews. The two main themes are influences which are facilitators of the DMP and those which are blocks. Permeating through all of the interviews are the aims to keep children safe and to promote their wellbeing which I have shown in the centre of the diagram and I have discussed in section 7.4.2.

9.2. **Facilitators**

9.2.1. **Views of the Child, Parents and School Staff**

Some of the main influences which are present for all 6 interviewees are the views of the children, parents and school staff. This involves the team members both gaining the co-operation of key people but also finding out from them what they want from the intervention and what they want to work on. In quote 1 a child wants to work on his temper so he is offered some anger management work. In quote 2 the interviewee identifies the importance of meeting the girl and asking her opinion before making a decision about what is happening and what should happen next.

1. *School were kind of as well, we don't know where to go we don't know what to do. So I did do some anger management work with him because that's what he (the child) identified, that he lost his temper a lot. (O2)*
Figure 23: Decision Making Process Influences
2. For me the little girl had elements of depression. She had a negative thought pattern in thinking that everybody hated her, but it’s not really enough information until you’ve actually asked what the little girl’s opinion is. (K2)

The mother wants some support at home around parenting (quote 3) so she receives that and because she does not feel confident to attend a parenting course at first she is offered a tailored package at home. Quote 4 illustrates that an intervention can be a package of approaches and within that package the parents’ active involvement in deciding what they could do rather than expecting them to do what the team member tells them is valued. In quote 5 the interviewee identifies how essential it is to have the active involvement of the class teacher in making the decisions about strategies. She describes in her interview how she works with teachers to create the right conditions for a collaborative working relationship.

3. Mum felt she’d like some support at home so that’s what we decided to put in. (C2)

4. ...interestingly after all that parents also came up with some things that they felt they could chime in with for the whole intervention program. (A2)

5. ...in actual fact I always make sure it’s an agreed list of strategies that are going to be tried if you like so that they’re made doable. (HP – for that teacher and that situation) Absolutely because if you don’t have that you’re not likely to get change are you? (P2)

There is however a recognition from them all that they are bringing specialist knowledge to the relationship (quote 6) and also that they have to make decisions independently from the parents or teachers (quote 7), in order to move the process forward.

6. So it was very much a collaborative planning meeting in the sense that what I did on that day was to outline the findings and then said something like if you look at the literature on difficulties of these kinds these are the sorts of things that can help. (A2)

7. (talking about an action plan) but I would sometimes with some families I would probably give them a couple of things we’re going to work on first, otherwise it would seem quite overwhelming to them to think that we’re going all this long way. (C1)

9.2.2. Therapeutic and Collaborative Relationships

The impression from all the quotes above is of a genuine desire to develop and promote a collaborative working relationship with the children, parents and teachers
in school. All interviewees comment on the importance of developing a positive therapeutic or collaborative relationship. The development of the relationship is often fundamental to the intervention.

8. **HP –...there was a good working relationship?**
    I - Yes definitely. I think it took quite a bit of time to build it up with Mum actually for her to actually open up and start being honest. She was very guarded when I first met her but slowly but surely over the weeks and months that I’ve worked with her that's finally fallen into place and I think she quite trusts me now. (C2)

9. **I would say the joint working is a massive factor and has a massive impact because if you've got parents on side and you've got the child on side and they're both willing to change then you know you're half way there before you've even started really.** (K2)

10. **It was a really positive teacher to be working with. So that kind of is the format that each of the strategies that we talked around kind of went. I'd bring something to the table and then we'd backwards and forwards suggestions or tweaking it to make it right so for her environment** (P2)

There is also the acknowledgement that this team is an early intervention team and not a statutory service so the family cannot be required but may need to be persuaded.

11. **But at the moment everybody is saying this is the issue, no other issues have been brought up so we wouldn't make anybody work with something that they don’t want to work with because it's their choice. It's about the consent and it's about the fact that we are early intervention prevention service, they buy into us. They can opt out at anytime they want to. So we would work with what they want to work with to a certain extent.** (L1)

The factors they identify which make for a positive relationship include building trust through confidentiality, shared values, pre-existing factors such as openness and willingness on the part of the family members and information provided by the team member which the family find useful in understanding their child better. In addition the importance of well run collaborative meetings is recognised as part of the development of a productive relationship.

12. **HP – what makes a better meeting?**
    I - For me valuing the parent and the young person, if the young person’s present, and fully involving them in making appropriate decisions (P2)
9.2.3. Data

As discussed before there are a number of types of data which are gathered. This data includes information provided by school and families as well as observations by team members and psychometric testing. There are clear references to the influence this bears on decisions about interventions.

13. Then trying to blend and synthesize that with the information the EWIST team had collected. So that would be understanding what was going on in the CAF, understanding things like the SDQ information and then thinking where that synthesis got us in terms of a formulation. (A1)

14. HP – Just thinking about that what would it take in terms of assessment for EWIST yourself to decide that it should be (outside agency) deliver it rather than perhaps yourself doing? I - Because I've sort of looked at the referral one little boy was anxiety related. I've read the assessment, the CAF and he was very anxious about everything, scared of letting teachers down. He was in a really negative cycle. (K2)

As discussed in section 7.3.3.1 there are concerns about the quality of information contained within the CAF form. Feedback from the team as a whole expressed some doubts as to whether a decision could be based on a CAF completed by someone else.

- If CAF is fully completed and family/young person has been involved directly with the information, yes I am comfortable.
- Yes but sometimes alongside other information
- Not solely on CAFs
- Again it is a starting point – from family bias
- Yes I am comfortable basing decision on CAF COMBINED with additional info obtained through discussion with Lead Practitioner (who has the perspective of where the clear needs are)
- I would be OK with the information on a CAF from someone else but would worry about the process – weaker relationship/rapport building.
- Before making a decision based around a CAF I would like more info. Assessment of young person (Feedback from team members – unknown)

The SDQ is completed before an intervention and as the case is being closed. It is not usually the deciding factor for closing a case. The data across the whole team is collected together and analysed on a regular basis. There are problems using it a systematic way to gather practice based evidence as described by the Team Manager:

It's very hard to monitor. We can have the impact. We can have pre and
post SDQ's and we can know that some CBT went on, but that was only one element of the intervention. If you are working in a multi-disciplinary team, if you are going to have somebody working with a parent, somebody with a young person, somebody with a teacher and although CBT was the main evidence based intervention because we are not in pure clinical settings to say that this was only about this particular approach is not feasible. (B1)

9.2.4. Beliefs and Theories

It is possible to identify the link between underlying beliefs and models of understanding and the choice of an intervention. In quote 15 there is a description of the circumstances within this family, the effect this had on the mother and an assessment of mother’s skills and then the direct effect this analysis had on the actions delivered by the interviewee. The theory in action appears to be risk and resilience with the emphasis on improving parental skills by empowerment through offering practical help to get started.

15. And then certainly when Grandma passed away Mum became quite depressed and I think not having anybody to speak to or to sort of support to look to the future. I did quite a few practical things with her like finding information from college together and she certainly seemed to need that little kick start to get going. So yes I think they probably would have been remained in the isolated place that they were because Mum didn’t seem to have the skills to find a way out of that. (C2)

In quote 16 the interviewee shows the link between the predicted outcome for the child if nothing is offered and the need to offer an intervention to the parents as well as work for the child. There are indications the process of formulation here based both on a combination of a biopsychosocial model and a medical model.

16. I’d more or less made my mind up at that point that I did need to see this little girl because if that pattern continued then it would almost surely be it would develop into a mental health problem with that sort of background that sort of family life. I knew it would be parenting. Somebody working with the parents as well. But I asked about that and at the meeting Mum said no he won’t have anything to do with it. “It's like I've got another child. Dad doesn't want to know he thinks it's not his problem and it's so childish” So she was well aware of what he was doing but she didn't think he would change or do anything about it. (K2)

9.2.5. Skills

In their descriptions of their own cases, but also in reference to decision making in general the interviewees identified, those who would have the necessary skills to
carry out an intervention. There are references to specific skills including training in parenting programmes and less specific ones such as experience of doing family work or one-to-one work with children or group work with children. In quote 17 and 18 both make reference to an underlying awareness of who in the team could do what.

17. Who has capacity and who has the abilities to carry out that work. (C2)

18. In that sense I think there is an optimal process happening already that people are aware of the constellation of possible input of team members and go and seek them out as needs be. (A2)

The decision about appropriate skills is not just about who within the team has the skills but also who from outside the team could be or should be involved. This includes, as in quote 19, an acknowledgement that an intervention requires a more skilled worker to deliver the level of intervention in an efficient way. Quote 20 shows how a particular decision point, namely a BEACh meeting at which the action plan would be agreed, is an opportunity to involve other agencies based on the information from the CAF form.

19. Although I probably could have seen him. I would have been looking because I'm not a therapist I think I would have looked at more, it would have been more longer term but with (outside agency) with them being a CBT therapist we're looking at six to eight sessions. (K2)

20. HP – Right so the next point of any sort of decision making was the BEACh meeting
   I - Because we decided who to invite to the meeting while we were there, after the CAF we sat down in the cluster and worked out who we thought would be involved. Then worked out if we needed to invite anybody else and we decided at that point not to, just to keep it within the team. (O2)

9.2.6. Joint working with team member

Decisions about interventions are influenced in practice by the knowledge that other team members can deliver complementary interventions.

21. I – I think so yes, yes I do. I think for the relationship side of it. I think it would be quite difficult probably especially in the earlier days to have gone into school and done the work and expecting the child to open up and feel they could trust you perhaps. Knowing you were still also seeing Mum around behaviour issues at home.
   HP – that needed to be two people?
   I – I think that worked better. (C2)
22. I think there are three cases where xxx does the parenting and I’m working with the child and it’s worked really really well. We have discussed it afterwards and said right what happened with your session with the parents and I’ve said what’s happened at home and we’ve discussed it and planned a new tactic to use. (K2)

Interestingly when I asked the interviewees whether they knew what their colleagues did in their interventions they were unable to tell me in any detail. It seems enough to know in general without knowing the details.

9.2.7. New information including subsequent events in family

The next two quotes (23 and 24) illustrate the effect on decisions with the emergence of new information about an event or a change in circumstances.

23. I think it was quite soon after or otherwise they might have rung us because they do ring if this happens yes there was a really violent incident. Nobody could really get to the bottom of why or what. I don't think the boy himself really knew how it had got to that stage so we came back and discussed that. (O2)

24. HP –So the next crucial time was the point at which thought right maybe one to one work for the wee girl?
   I - Yes I picked up the information from Mum that Grandma was becoming more unwell, that the family was becoming more chaotic because everyone was trying to get involved in the care. (C2)

I also noticed this in my observation of the cluster meeting. There were several mentions of new information coming to light. In some cases the information was hearsay but, because this heightened concerns, further decisions were made which included offering support such as involvement in a group programme, home visits and referrals to other agencies.

9.3. Blocks

I had asked in the interviews what would have stopped the optimal decision being made in the case they were describing to me, but also what stopped the optimal decision in general.
9.3.1. **Staffing levels/time**

Four of the interviewees referred to staffing levels as in quote 25. This was related to staff absence and team members having to cover in other clusters.

25. *I'd say staffing levels. I've got six seven cases in xxx which isn't my cluster and I'm in the xxx cluster and I would love to be working with more children.* (L1)

9.3.2. **Lack of information or poor quality information**

Quotes 26, 27 and 28 are the dark side of the data theme above and refer to the difficulties caused by a lack of information or poor quality information. This is often referred to by interviewees and was also observed in the cluster meeting. The suspicion that information is not accurate or sufficiently complete leads to the decision to gather more information until the team members are satisfied they have enough. In the cluster comments were made expressing surprise at the poor quality of information from a school which usually supplied good quality information, good in the sense of more complete or more informative. There appears to be a level of information, which they can all recognise, which feels sufficient to base decisions on.

26. *The decision will be go away and get some more information as we can't make an informed decision about this.* (L1)

27. *In this case Mum was quite honest, but you never know there might be something else that you don't know there could be a piece missing. You can't deal with that if you don't know.* (O2)

28. *Other occasions we will bring a case to the table that is a little bit more complicated. There's much more going on we know we've only got a snippet of what's going on and we need more information. So we'll make an agreement that somebody in the team will go and complete a CAF in more detail perhaps or even if a CAF has been completed by school somebody will make a home visit and try and gather more.* (P1)

9.3.3. **Lack of specialist skills**

This is an example of the lack of a skill being a barrier to making the optimal decision.

29. *The team where specialist services are not there like speech and language you know. They are things we battle against all of the time there's a real need and those things are not covered. I suppose we have obviously got the EP's but I know there's specific learning difficulties and things like that*
sometimes you know aren’t there so more staff or maybe more specialist..
(O2)

9.3.4. Lack of initial co-operation from parent or teacher/lack of working relationship

The interviewees also describe how a lack of willingness to work together or develop a working relationship can stop any intervention from taking place.

30. Sadly I’ve been recently to another school where I felt I’ve broached this situation exactly the same way. Yet it was quite clear I think the teacher might have felt a little threatened by me and was almost like paying lip service with some of the ideas as much as I was trying to push back. Say well this is going to work for you. You tell me what is going to fit in your class you know all of that and I returned and upon review maybe there was one strategy that he’d even attempted and the others very quickly dismissed and barely continued. (P2)

31. It’s whether everybody’s on board. We worked with another boy in the same year at the same school and that didn’t work because mum wasn’t on board. Didn’t want any support and the little boy he was just a bit I don’t think he was that bothered about what we were doing. (O2)

9.4. Conclusions

Research question 3: What influences the choice of interventions and why do the team members make particular choices of interventions?

Choices of interventions are influenced by a number of different factors some which facilitate and some which block the choice. These choices sit within the overarching framework of keeping children safe and promoting their welfare. One of the strongest influences on these choices seems to be the taking into account of the views of the child, parents and school staff. Building productive relationships with parents, children and schools staff underpins the interventions. This is related to the importance of building productive relationships with parents, children and school staff. The risk and resilience model is also a strong influence as often the choice is based or reducing risks and building resilience. Other models of understanding determine the actual intervention. Additionally there are a number of pragmatic influences such as the availability or lack of certain skills.

Compared to an evidence informed approach using diagnostic labels linked to particular interventions this is a far more pragmatic approach – reduce risk and
promote resilience through developing good working relationships with school staff and families. Specific evidence based approaches are employed in an eclectic way when they seem appropriate in the view of the practitioner. They do not analyse outcomes’ data systematically to inform future practice.
10. DISCUSSION
In this chapter I will present a summary of my findings under five headings. These findings are an amalgamation of the conclusions from the last three chapters. I will discuss each finding in greater depth including highlighting their contribution to knowledge and their implications for practice.

10.1. Summary of Findings

1. Team Decision Making Process
The study team DMP is a complex, iterative process which is facilitated by a predetermined organisational structure and continues throughout the assessment and intervention stages. This is built on the common assessment framework process. The views of different disciplines are welcomed and merged into a shared DMP involving not just the team members but also and very importantly the families and school staff. The interviewees feel that the process is equal and the views of different disciplines are valued and utilised to make decisions. The structure builds in opportunities for checks and balances in the decision making. In addition the structure, especially the cluster meeting, appears to provide professional and emotional support to the practitioners. Trust and understanding has grown between the practitioners as a result of the contact in the cluster meetings, shared offices and joint training. Given the complexity of the issues they are working with they appreciate having practitioners from different disciplines in the same team. It does appear that the diverse views add value to the DMP and potentially to the interventions and outcomes for children.

2. Individual Practitioner - Decision Making
There are some indications that the practitioners use their intuition (a process below conscious awareness) as well as a step by step process demonstrating the links between causal explanations and their choice of interventions.

3. Models of Understanding
There is a very high level of agreement in the way team members conceptualise the circumstances, even though they rarely named models spontaneously in their interviews. They generally use a risk and resilience model with a solution focused approach underlying interventions. Other models of understanding can be detected in their narratives. There is a strong pragmatic element to the narratives in that the
team members describe finding and adapting solutions whatever the circumstances and at all times trying to keep children safe and promoting their wellbeing. They do not appear to follow an evidence informed approach using diagnostic labels linked to particular interventions and following manuals or fixed interventions. Specific evidence based approaches are employed in an eclectic way when they seem appropriate to the practitioner. They are not systematically analysing outcomes’ data to inform future practice.

4. **Involving Others in the Decisions**

The involvement of children, parents and school staff in the process is welcomed, facilitated and valued. Decisions about interventions take into account of the views of the child, parents and school staff in order to build productive relationships as these are seen as essential to ensure good outcomes.

5. **Mechanisms which trigger effective decision making**

The mechanisms that facilitate effective multi-disciplinary working are in evidence in this team and may also be relevant for understanding effective decision making in multi-disciplinary teams.

10.2. **Team Decision Making Process**

10.2.1. **Contribution to Knowledge**

The DMP in this team appears ideally suited for the emotional demands and complexity of the casework involved. An assumption might be made by those unfamiliar with early intervention and prevention work that in some way it is less emotionally demanding than more specialised work. However:

*It is well recognized that child protection work is emotionally demanding, but our early findings have shown that some practitioners felt that early intervention work (CAF and LP) can also be emotionally draining.*

(Brandon et al., 2006b: p. 411)

Very high levels of need exist in the casework described to me, such as families experiencing domestic violence, drug and alcohol abuse and parental mental health issues which are all known risk factors for emotional wellbeing. In addition the fact that there are children referred repeatedly to social care but not accepted is well
recognised in this LA (Broadhurst et al., 2010). This has a level of impact on practitioners which has been identified in other research for example in an evaluation of a Sure Start. However in that situation it led to difficulties with decision making in a meeting because the practitioners did not feel supported by colleagues (Morrow et al., 2005). In contrast, in this team the practitioners feel supported by colleagues from other disciplines.

As well as the emotional level of impact on practitioners they are also affected by the complexity of problems presented in casework. I discussed the nature of complexity in relation to decision making in section 3.13. This team’s DMP provides ways to cope with these aspects of complexity. Instead of one individual practitioner making a decision in this team there are opportunities built in to the process for checks and balances in the thinking behind the intervention. This seems ideally suited to the complex environment in which these decisions are taking place. The usefulness of the DMP in this team is that work around and with each child is under constant review through the regular cluster meeting, which comprises different but equally valued disciplines, and the link meeting. If there is a change in the child’s environment then this structure provides a way to review and to alter the intervention.

Information which might be stored in practitioners’ heads (section 7.3.3) and not be available for other practitioners, a problem acknowledged in social work (Munro 2011), is regularly shared, discussed and recorded at the CMs. There were examples of colleagues checking quality of data and actions, with on the spot expert contributions from trusted and readily available co-workers providing reassurance in emotionally demanding situations (Brandon et al 2006b). In addition the presence of different disciplines at the CM provides access to practitioners who can work across boundaries as described in the literature review in section 2.4.

It is well recognised that practitioners from different disciplines can have interpretation problems through the lack of a common language and different models of understanding as discussed in section 2.5. Frost (2005) in the review of multi-agency working describes two processes by which practitioners overcome differences in models of understanding. One way is that through working together they learn from the other practitioners in the team but retain their own distinctiveness. On the other hand some teams in his research report merging models to develop a new model which forms the basis of practice. In the team
have studied they have both the shared tools and models of understanding but at the same time they have retained their own distinctive perspectives and these are respected.

The value of different perspectives is recognised in the study team as described in this definition of perspective: ‘not a recipe; it does not tell you what to do. Rather it acts as a guide about what to pay attention to, what difficulties to expect, and how to approach problems’ (Wenger 1998 p. 9). In discussing complex problems Bore & Wright (2009) argue that it is necessary to use context and ‘the lens of knowledge of that context’ (p. 248) and furthermore that:

This contextual knowledge can only be gained by using trans-disciplinary approaches which incorporate not only disciplinary observations, and the practice perspectives of the professionals involved, but also the actors at the social or community level (p.248)

In the Hackney social work model described by Munro (2011) she reports that the teams also value the ‘additional perspective’ (p. 155) provided by clinicians and child practitioners.

It has taken time to achieve this, as recognised in other research (Frost 2005) though joint training has helped (Robinson & Cottrell 2005). I would argue that the study team benefits from the regular CMs which allow these perspectives to be shared very regularly and apparently without conflict. In contrast Annan et al. (2008) recognises the difficulties that can be encountered with a high level of diversity in teams but they conclude that it is valuable. The CM and the DMP as a whole sounds similar to the process within teams in Hackney (Munro 2011). The cases are held by Social Work Units, which consist of a Consultant Social Worker, a Social Worker, a Children’s Practitioners, and either a Family Therapist or Clinical Practitioner. All families and children are known to all members of the team but work is undertaken by different members of the team as appropriate. All cases are discussed weekly. The meeting described here sounds very like the cluster meeting:

This is the key forum for updating information, analysis, reflection, planning and decision making. Providing different expertise and perspectives within the social work unit aims to enable a better assessment of risks to the child and a broader assessment of interventions (p 155).
These two models have arisen separately and independently. In contrast to the Hackney model there is a wider range of expertise available to the practitioners in this team with the addition of educational and clinical psychologists available to consult, thereby avoiding lengthy referral processes. Furthermore within the CM there is no formal hierarchy based on professional responsibility as there would be in the Hackney model as anyone in the CM can be the key worker for any child. Although my observation of one CM indicated that certain team members do take on the role of leader or facilitator within the meeting. The implications of this for the DMP would need further research.

10.2.2. Implications for practice

One clear implication for practice is that those in the position of setting up a team for children’s services within the arena of “promoting emotional wellbeing” should allow time for people to develop trust and appreciation of each other’s unique view. Care should be taken to offer opportunities to train together and to develop common models whilst retaining diversity in knowledge and skills. The DMP within a team should not be left to chance. It appears here that a predetermined structure allows for checks and balances which are built in.

10.3. Individual Practitioner - Decision Making

10.3.1. Contribution to Knowledge

In this in-depth study of one team’s DMP there is evidence that individual practitioners are using intuition, as predicted by the Dual Process Model discussed in section 3.6. Intuition is not necessarily a reliable tool for decision making and as described in the literature review it is an unconscious process and is not available for reflection. Therefore, given that people will make judgements below conscious awareness, it would be helpful to know when to rely on intuition and when not to rely on it. Munro (2011) discusses the importance of this in the context of social work.

Intuitions are likely to be more skilful when someone has built up expertise over time in "an environment sufficiently regular to be predictable and an opportunity to learn those regularities through prolonged practice" (Kahneman 2011). The process requires feedback. There are some contexts such as learning to drive a car where the feedback is immediate and we can learn how to manoeuvre. In circumstances such as therapeutic work with a client a psychotherapist can gain feedback in a
session that helps them to be able to predict what their client is thinking or feeling in the moment but they are poor at predicting long term outcomes (Kahneman 2011). In the team studied there is lack of regularity in the environment both in terms of the feedback and in terms of the process of change in the child’s circumstances. In the individual sessions with child, parents and school staff members it is possible, as in psychotherapy sessions, that the practitioner could gain feedback by observing how an individual reacts to a particular comment from the practitioner. This might go some way to explaining the importance placed on the relationships being developed with parents, children and school staff. The instinct of team members that developing a co-operative relationship with parents, children and families is of fundamental importance has credibility, as I will discuss further below in section 10.5.

There is a possibility that the nature of the DMP in this team provides another source of feedback over time. Each practitioner attending the CMs is joining in a process of collectively reviewing and reflecting on the work with each child from a school in that cluster. In essence the structure involving the CM is providing a decision feedback loop. This provides the average practitioner a far greater number of cases to learn from than the average case load. However I think that two important elements are lacking. One is the knowledge in detail about what an intervention actually involves, as discussed in section 9.2.6. The second is a reliable measure of outcome for each child at the point prior to closure of the case. I discuss this issue further in section 10.4.1 below.

10.3.2. Implications for Practice

Current decision making research concludes that we all use intuition and in some environments we develop expertise and rely more on our intuition. However there are warnings about relying solely on intuition. This has real implications for practitioners in children’s services. It is necessary to both pay attention to intuition and also know when not to trust it. Some way to test initial feelings is needed and to check them throughout the process of working with a particular child and family. The usual process within social care and in the health services is for supervision by another practitioner, sometimes but not always a line manager. As discussed in section 3.9 Schön proposed a role for reflection for professionals working in complex situations. However if some thinking is not open to conscious awareness then how is reflection on decision making possible? In a number of aspects of the
In Chapter 4 I discuss the need to integrate three types of knowledge in decision making: case knowledge, experiential knowledge and research knowledge. This model, especially the CM, seems to provide a way for individual practitioners to do this. In this arena all three types of knowledge are fluid. Firstly case knowledge is not static. It changes over time and is inherently uncertain. Secondly in this team the practitioners have come from very different backgrounds with different levels of training and work experience. This is the reality of the children’s workforce. And thirdly in section 4.4.5.4 I argue that research evidence is hard to access and to synthesise into practice (Munro 2011). The CM is a time and a place when the three types of knowledge can be overtly integrated, synthesised and reflected upon.

It takes time to integrate new learning into practice and it is not always a conscious process (Munro 2011) and time is of the essence as can seen in this team where on average 4 minutes were assigned to talk about a child at the CM. However as the child will be talked about over several CMs and on other occasions besides formal supervision each practitioner has the opportunity to learn not just from their own work but also from other people’s case work as well. To make the most of this opportunity it would be helpful for practitioners to articulate their thinking more clearly possibly in a more structured way, which I discuss further below.
10.4. Models of Understanding

10.4.1. Contribution to Practice

A risk and resilience model and solution focused approaches have provided a common language and shared understanding for this team. This resulted from the initial planning (deciding to use the CAF process) and training (in both models) as discussed in section 8.1. They also fit with the beliefs held by the practitioners, which include reducing risk, promoting resilience and ensuring that children, parents and school staff are involved in the process. It is also being recommended as a model which can be usefully applied across different agencies in multi-disciplinary work (Croom & Procter, 2005). Furthermore it is also noticeable that the risk and resilience model allows other approaches to fit under the same umbrella. As stated in the TaMHS (2006) guidance the therapeutic approaches they identify in the document “all address risk and resilience factors to some extent” (p. 28).

However as most of the interviewees rarely named the models they were using I am uncertain to what extent they were aware of the implications of the approaches they were employing. Theory or models are important both to the members of the team and also within the children’s workforce as a whole. The importance of understanding theory is recognised by the Children’s Workforce Development Council who produced the Common Core of Skills and Knowledge in 2010 as part of the Every Child Matters agenda.

\[\text{Know how to use theory and experience to reflect upon, think about and improve practice. (Children’s Workforce Development Council, 2010: p.12)}\]

I would argue that it is important, if practitioners are intervening in the lives of children and families, that there is an understanding of why they are offering what they are offering rather than just delivering an approach off the shelf or randomly. Understanding is important so that they are consciously able to adapt the approach for the particular child in that particular family at that point in their lives. If they do not understand the theory behind the model they are applying then they will not understand the implications of any variations they employ. It is essential in the application of evidence based practice and practice based evidence to understand underlying models as discussed in sections 4.5 and 4.6. (Munro 2011b).
The approach in this team could be described to some extent as delivering interventions which produce serendipitous outcomes not treatments which are based on a sound knowledge of causal mechanisms and disease trajectories and which are rigorously evaluated. This could be a criticism of the team approach. However there are reasons why this is both understandable and acceptable. Firstly there is the argument, as outlined in the TaMHS document (DCSF, 2008e) which takes an evidence based approach and discusses the evidence hierarchy while acknowledging that “it is important for practitioners to recognise that all evidence-based reviews are inevitably generalisations, and will apply to a greater or lesser extent to individual children and families” (p. 31). Secondly there is the position that in fact this work is not about diseases and that a strict positivist stance is not appropriate as discussed in section 4.4.5.2.

The approach taken in this team with individual children and families is more flexible and in my view likely to produce solutions in complex situations. How they describe the selected children and their circumstances and my observation of the CM when many children were discussed highlighted the changeable nature of the situations. These are complex systems. The child, the family and the school all provide the possibility for therapeutic change but also, and inevitably, the cause for unexpected and unpredictable change. One practitioner on their own providing one intervention would have to deal with these events or ignore them. Instead in this team each practitioner has the support of their colleagues both in reviewing the current circumstances and in deciding how to adapt their approach when necessary. The risk and resilience model delivered by a multi-disciplinary team in this way allows flexibility of approach and a quick response as circumstances change.

Unfortunately this type of work in these circumstances is very difficult to evaluate, and this, I would argue, leaves a gap in their learning as individual practitioners and also makes measuring the effectiveness of their team work harder. There should be a concerted attempt to gather evidence and to measure the effect of interventions on outcomes. This team has measures, such as a Strength and Difficulties Questionnaire, but these are rarely collected before the end of an intervention, and are mainly analysed at the end of the academic year to review the performance of the team as a whole. At best this measure could show change in a positive direction which could lead to the mildest of conclusions about the direction of travel for the team as a whole. The other main way that outcomes are measured is through
gathering the views of the participants. However this method is too variable to provide a reliable measure of all the casework performed by the team.

10.4.2. Implications for practice

I discuss in section 4.6 other ways to measure outcomes. One method which could have provided the practitioners and team as a whole with a measure which could be used across all cases, and would fit with the CAF process, is Goal Attainment Scaling (Dunsmuir et al 2009). Using this approach, practice based evidence could be gathered and linked to types of interventions.

It would also be very useful to have a collective view of what actually happened in different interventions. The details of an intervention have to be known in order to link a particular intervention with the outcome for a child. This is important to gather practise based evidence. If there is a reluctance to enquire closely into the details of an intervention as discussed in section 9.2.6 then I suggest that managers and supervisors should be challenging this.

If a multi-disciplinary team is being created then taking time to ensure that there is a shared model is recommended. It would appear from this team that although joint training and time spent together in the office may be helpful it was the joint DMP within the cluster meetings which was developing the shared understanding.

10.5. Involving Others in the Decisions

10.5.1. Contribution to Practice

Inclusion of all parties in the process was a very strong theme running through all the interviews. It is true both for those working more often with the children and parents and those working with school staff. There is an element of empowerment, but also a pragmatic realisation that without active co-operation interventions will not be effective. It was not discussed as an ethical issue. The acceptance that parents will be part of the process is encouraged by the use of the CAF but also because parents and staff are seen to have knowledge and solutions to offer to the package. The importance of a positive therapeutic alliance is recognised in the literature (Green, 2006; Karver et al., 2006; Shirk & Karver, 2003). The importance for parents of a relationship with the key worker is well recognised (Hingley-Jones & Allain, 2008; Lippell & Jones, 2008).
It is seen as a skill to be able to involve parents successfully in the decision making process. The interviewees believe it is part of their role to perform this skill and to model it to school staff. It is interesting to contrast the regular and expected attendance of parents at the CAF meetings in this study with the finding from the study of Gilligan & Manby (2008). In that study, of a small northern town implementing CAF early, the mothers engaged with the process and were positive about their involvement but the decisions were made at multi-agency panels to which parents were not usually invited. On the one occasion observed by the authors they note that those present had not planned beforehand how to facilitate this meeting with a parent present and only due to the resilience of the parent and the instinctive skills of the practitioners was it successful.

The national evaluation of budget holding lead professionals (Walker et al., 2009) found that:

*It is evident from our interviews with families and from the case studies that we presented in Chapter 10 that families tended to appreciate their involvement in both the CAF and the TAC, and that both these processes empowered families to play a more active part in assessment and in decision-making, thereby increasing their buy-in to that relationship with their LP.* (p. 301)

An area I did not explore in detail with the interviewees was the BHLP aspect of the team. However it is interesting how close to the child and family the budget decisions could be made as the manager of the team could sign off sums of money in contrast to:

*While we found evidence of increased family empowerment via the CAF and TAC processes, the practitioners usually remained firmly in control of the decision-making process about expenditure and of the assembly of an integrated package of personalised support.* (Walker et al 2009 p. 308)

In contrast to the team around the child approach discussed in the BHLP evaluation, which would involve teams of practitioners coming together to work with one child and their family and then disbanding again, the team studied benefits from the regular contact over time in CMs and link meetings with those also working with the family. This I would argue provides the practitioners additional time to develop trust with each other and knowledge about each other’s skills.
An interesting contrast exists with the strong belief that families should be at the
centre of decision making both in the BHLP evaluation and this research. Walker et
al (2009) identify that there are some families who want decisions made for them
and in this research there is the example of the practitioner who was quite clear that
although she would have consulted about actions she would be careful not to
overburden the family with too much. There is an element of skill and knowledge
involved in deciding how much to share and how much to keep in reserve.

10.5.2. Implications for practice

There are implications for the training and development of the children’s workforce
and perhaps controversially this means school staff members as well. The one
example mentioned in this research of a poorly run meeting was that chaired by a
school staff member and as identified by Shucksmith et al. (2005) it was often the
educational practitioners who did not involve children and parents in the decision
making. In the future, especially with the development of academies, school staff
members are more likely to be chairing meetings and trying to engage and involve
parents and children around aspects of emotional wellbeing. Involving children and
parents in both the CAF process and the DMP is a skilled task. It is not enough to
simply bring people into a room together. There needs to be a process which
involves people prior to meetings. A meeting needs to be carefully chaired. People
need to feel valued and involved (Harris, 1999).

10.6. Mechanisms which trigger effective decision making

10.6.1. Contribution to Practice

Critical realism requires a thorough description of the context and an identification of
the mechanisms which trigger an outcome. I offer the suggestion that the facilitators
which have been identified in relation to effective multi-disciplinary working (Chapter
2) could also be those necessary for effective decision making in a multi-disciplinary
team. Most of these facilitators are present in this team. Some resulted from the
initial decisions made when the bid was written: joint aims, a joint funding stream
and joint strategy. Others were created during the development of the team: joint
processes and common tools. The joint training around models has led to common
models and a common language. Time together has reinforced the shared beliefs,
which include the importance of building relationships with families and school staff
and the importance of keeping children safe. Time together, from co-location but also from the regular cluster meetings, has also developed trust and understanding. There is clarity of role and there are skilled boundary workers and link workers. There appears to be a positive organisational climate although this was not directly talked about, but very little evidence of conflict was revealed in the interviews and there are frequent positive comments about this way of working. However my impression is based on a small sample within this team and they may have been reluctant to share examples of conflict given that I am also a colleague in the authority.

In addition to the known facilitators for multi-disciplinary working in this team, the DMP has a structure discussed in section 10.2 which provides checks and balances. There is a degree of flexibility about who does what and in how decisions are made. The direction of travel can change quite quickly in response to new information. Regular contact with practitioners from different disciplines provides an ongoing learning experience which could contribute to the development of expertise while doing the job. There are also the necessary skills available to ensure that parents, children and staff are all part of the DMP.

There are also some mechanisms which are believed to block effective decision making which include lack of services, lack of time, not knowing or recognising one’s own model of understanding and not gathering systematic outcome data.

10.6.2. Implications for practice

Some of these mechanisms take time to develop. It takes time for people to learn to trust the others in the team and to understand their thinking. This should be considered against the backdrop of change discussed in Chapter 2. One repercussion from the changing of government and local policy is that the length of time available for this trusting relationship to develop can be short. If teams start up and are then disbanded each new group of people has to start from the beginning again. In addition there is the issue of practitioners developing expertise as discussed above. This type of expertise is not developed in classrooms or through reading manuals. There are advantages to a structure that ensures time for regular discussions around cases. This model appears to have advantages over a multi-disciplinary team in which people carry out casework independently, meeting only in the office or at team meetings.
11. MODEL FOR SUPERVISION

11.1. Introduction - Attributes Model

During the analysis of the three research questions I had noticed a pattern arising. I think that this is another interesting contribution to knowledge and to practice. I started to categorise what I have called attributes of the DMP process from the themes I had already extracted. Figure 24 shows those attributes which appear to represent distinct features of the process expressed as a continuum. The first five dimensions (white) refer to features of the decision making process and the last three refer to features of the intervention (blue). The diamond shade marker can be moved along the line to indicate which end of the continuum the DMP is closer to.

![Figure 24: DMP Attributes Model](image)
Iterative - One-Off

One striking feature of the DMP of this team is that it is iterative and rarely one-off. The team return to each case at each cluster meeting, at regular review meetings and even at the regular link meeting. At each of those meetings it is possible that new information is considered or there is recognition that something is not working which results in a new approach or a change of plan being decided. However if decision making within the mental health arena is concerned it would be very possible that a one-off decision is made.

A series of decisions – I suppose the first bit is quite structured and obviously as you’re actually doing the work you make decisions as you go along. If things aren’t working then maybe we’ll try something else.

(O1)

Equal - Unequal

This dimension is measured by how the participants in the decision making feel about the process.

HP - and so in terms of kind of offering thoughts and opinions and views that feels like an equal process that’s going on?
I - Yes it does to me within our cluster meeting. (C1)

Shared - Unitary

Within this team there are examples of both shared decision making and unitary decision making. In most cases the decision making which takes place within the cluster meetings and the CAF meetings is described as shared.

I think it feels shared in as much as, yes we do talk about it and we do make those decisions. (L1)

However at times all team members describe situations, sometimes involving themselves or sometimes another member of the team, when a unitary decision is made usually when there is some specialist knowledge involved and often when a referral to another service is involved

HP - Was that you making a decision at that point or was it a shared decision with xxx?
I – I think it was predominantly my decision. (A2)

Collaborative – Authoritative

In this next dimension I want to represent the very real sense in this team of the collaborative nature of their work with the children (1, 2), the parents (1, 2) and teachers (3).
1. **HP – What makes a better meeting?**
   1. - For me (it's) valuing the parent and the young person if the young person’s present and fully involving them in making appropriate decisions. (P1)

2. I suppose it goes back to the non judgmental stuff I am here to help you it's your family you know what you want I am here to help you. (L2)

3. It was a really positive teacher to be working with. So that kind of is the format that each of the strategies that we talked around kind of went. I'd bring something to the table and then we'd backwards and forwards suggestions or tweaking it to make it right for her environment. (P1)

The collaborative end is contrasted with the authoritative end. I wanted to represent the times when decisions are more clearly based on someone’s expertise or specialist knowledge. This decision could still feel equal but the balance has shifted towards a more unitary decision. The interviewee (4) is describing an occasion when a team member who had more specialist knowledge about the agency to which the referral was sent and also more background knowledge from their discipline which was acknowledged and welcomed by the interviewee. Quote 5 illustrates the value for all those interviewed of having team members from different disciplines. There is still a discussion a sense of equality and even perhaps a shared decision in the end but there is an authoritative element to the knowledge being brought to the decision which is held by one or two people.

4. I think it was coming up to Christmas.... actually that's right we had a discussion in the cluster meeting and xxx thought a referral to the ZZZ was the most appropriate action, but that was after a year of working all these things had been put in place but still there was something that hadn't worked. (O2)

5. The more complex cases come when we've got safeguarding concerns definitely which is where we've really got the benefit of our social worker in the team and the mental health element as well. So those are when we get a bit more lead. (P1)

**Personal Values – Formalised Ethics**

This attribute arose from the discussion at the start of each first interview when I asked if they were part of a professional body. I was aiming to identify if this would be an influence on their work. Those who are members of professional bodies acknowledged the influence but for all there are also their own personal values.

6. **HP – Do you feel that there is a sort of ethical guidance to the way that you do your job?**
   1. - Yes, but I think I have always felt that without registration. I think
that has something to do with professional values.
HP – Right, is that from your training then, do you think that is something from your training?
I - Partly yeah, but also partly about personality and the way you are, and the values that you hold as a person I think. (L1)

The team manager also recognises that different values between team members as a potential problem and one she felt the team were still exploring. However it is clear to me from the interviews, and can be seen to be recognised in the RQ3 discussion, that one fundamental value is the importance of collaborative working in the sense of equal value and respect for all those participating in the process.

Intervention Attributes

Pragmatic – Theoretical
I am using theoretical here to indicate a formal, research based type of intervention. There are examples where the intervention on offer has a clear theoretical basis such as a course from Triple P. On many occasions the intervention seems to be a pragmatic choice based on the views of the interviewees and the negotiations with the child, family and school.

Negotiable – Fixed
This dimension is captured in the following quote.

7. and through talking to parents of what realistically they feel they could put into place is probably the main thing I would say. (C1)

At the other end of the dimension would be an example where the offer is one type of intervention and if this is not what the child or family wants to do then intervention is not delivered. This team works hard to bring people on board.

Additive – One Intervention
An intervention could be delivered as a discrete piece of work but in this team in many cases there would be a number of interventions described which would run alongside each other.
11.2. Potential Uses of the Attributes Model

Professor Eileen Munro makes recommendations in her report (Munro, 2011b) which have relevance for the whole of the children’s workforce. Given that many children who might be considered to have reached the thresholds for social care input have first been seen by universal and early intervention services and may well return to them for further input after social care input I think we must not underestimate the level of complexity involved in this level of case work. She recommends a social care system that values professional expertise and encourages the use of research and theoretical models to inform practice. This applies equally to early intervention services. She talks about multi-agency training, but concentrates on the development of social workers.

In this study the level of complexity faced by the practitioners in the targeted mental health team might be surprising for some. However from my personal knowledge of working in this local authority it is not surprising. Practitioners working at those levels are often faced with decisions about whether or not to refer onto social care or tier 3 CAMHS and even then they often have to continue working with the children and families as referrals are not always accepted by higher level services. The complexity of families and children in schools is no less because the child may not be at risk of death, often now a threshold for acceptance of a referral to social care. Based on this study and given the complexity of early intervention case work I believe we should be thinking about how better to develop and support the professional judgements of children’s services practitioners other than social workers.

This model could be used as a way of analysing decision making in the context of multidisciplinary work with children and their educational, emotional wellbeing and/or mental health needs. I took this model back to the team manager and we agreed that it could perhaps be used as a supervision tool to aid reflective practice or in team development to aid discussion about practice or as a conflict resolution tool for practitioners differing opinions. She liked the fact that it was neutral with no implied superiority of either end of the continuum. Reflective practice and supervision as a way to develop and enhance expertise was discussed above and is highlighted by Munro (2011b). Wackerhausen (2009) argues that reflective practice is hard to achieve once a practitioner has reached a certain level of
expertise or at least familiarity with their area almost as though the professional immune system tries to fight back against any new ideas or ways of behaving. He recommends second order reflection, which requires that the practitioner becomes a ‘stranger to oneself’ (p. 466). Second order reflection in his view requires that practitioners think differently from their usual way of thinking and use concepts from different disciplines. He recommends inter-professional collaboration, which would need to take place in an accepting and relaxed atmosphere, as it would introduce new concepts and ideas. I would suggest that the attributes model could help to facilitate the process. This could be a model of peer supervision with no implied hierarchy. A practitioner could use the model to identify their usual style of decision making and then with a support colleague from a different discipline explore different styles. If this improves reflective practice this could help promote the development of expertise, which could then improve decision making. In addition Hemmelgarn et al. (2006) describe the problems with implementing evidence based practice across CAMHS and they stress the importance of organisational climate and the need for support to practitioners to encourage the adoption of new interventions. This model could open up the discussion in a non accusatory and collaborative way.

11.3. Implications for the role of the EP in multi-disciplinary team
Although the role of the EP has not been the sole focus of my research I think there are some interesting implications for the contribution that EPs can make. Helping all practitioners to understand how and why they make the decisions they do and linking practice to theory could be a role for EPs. The tool above could be used to facilitate this process by using the different attributes to explore individual decisions or shared decisions by practitioners in a reflective manner. They could explore the different causal explanations and theoretical positions being taken by practitioners. Dennison et al. (2006) use three different theoretical perspectives to discuss their own experiences of working in multi-agency teams. They suggest in their conclusions that educational psychologists could take a role of encouraging not just personal reflection but also encourage teams they are part of to reflect on and make explicit their perspectives. Annan et al. (2008) suggest a role for EPS in helping to make explicit different causal explanations using a tool which shows different perspectives on the learner and their environment. The attributes model could be used by EPs to model reflective debriefing of decision making patterns for both individuals and teams.
12. Final Thoughts on My Research Journey

Following a critical realist stance I have developed a rich picture of the decision making process in this team by its practitioners. I have identified mechanisms associated with effective decision making. How these decision making mechanisms lead specifically to better outcomes for children and young people needs further exploration.

12.1. Limitations of Research

In Chapter 5 I discussed the limitations of my chosen methodology. In retrospect there are two changes I would have made. Firstly in developing the interview schedule I think my choice of the word “circumstances” when I was trying to elicit views on models of understanding was too confusing. It had to be explained to all interviewees. However I still want to avoid the use of the phrase “model of understanding” as I would not want to impose that idea on the interviewees if they did not use it naturally. I would substitute the prompt ‘what word or phrase would be most commonly used’ with the prompt “how would you explain why the child is in this situation now?”

Secondly if time had allowed I would have conducted a pilot to create a picture of the DMP and then explored with the team members their views on which are the important mechanism involved in the process. However as I discuss in Chapter 5, due to developments within the local authority and nationally as I neared the end of my analysis stage it was not appropriate for me to return to the team for further discussions. In particular I would have liked to share with the whole team the final attributes model in Chapter 11. This is an area I would like to take forward in further research.

12.2. My Journey

On a personal note I have found the opportunity to study closely the decision making of other practitioners a very valuable experience. Conducting the research has not been an easy journey. I have had to reconsider what type of world I am studying and working in and therefore what research methods to use here. As I discussed in Chapter 1 and 5 this is an issue within the profession of educational psychology, and for me it is an issue very closely connected to how I practise my profession. I work within an environment where school staff and parents believe that it is possible to have certainties. They want certainties. They want a label to
describe their child’s difficulties and they believe that once a label is provided a solution will follow. I have no such certainties. I believe that research can uncover better approaches, but in applying a solution in a particular context we are dependent on so many factors outside our control, which include school and/or family systems and all the known and unknown rules, procedures and roles which form part of these systems. The children are not simple black boxes waiting for an input to produce a particular output. They are thinking, feeling human beings with views of their own. In choosing a critical realist paradigm I am moving away from the pure positivist approach, implied by a standardised testing and a child deficit model, and moving closer to the consultative approach held by social constructivists but retaining the belief that there are commonalities across situations.

Taking the time to read the decision making research systematically and in-depth also had an impact. The way that the interviewees opened up their thinking and shared it with me far exceeded my expectations. As a result of the literature review and the data collection and analysis I have explored my own decision making and I have produced a series of prompt cards with which I review my practice. I have also become more explicit about my thinking with families and school staff. For example I more frequently explain the link between the questions I am asking and the particular hypothesis I am exploring. I think that this is not only more empowering for others it is also a useful check on my own DMP. I see my role as helping to create a coherent narrative which involves a way of understanding what is happening within the current context, and which suggests alternative and additional approaches for those working with and living with the child or young person at the centre. Fundamentally this is also a collaborative approach as I believe it is essential to the success of any approach to enlist the active and intelligent involvement of the child or young person, the parents and school staff members. In order to engage with people in this way it is necessary to really listen. I am aware that if I do not understand their point of view they will not connect with me and my ideas.

Research and practice are very closely connected within educational psychology. Throughout my years as an EP I have been involved in research in some way. Often the research has been directly related to current projects and the exigencies of the job have meant the research has been quick and to some extent superficial.
Over the last 6 years I have had the time to be more systematic and thorough in the steps of the research process leading, I believe, to more robust findings. In addition I have had opportunities to become familiar with new research tools and methods such as thematic analysis and NVIVO. The effort involved in conducting a piece of qualitative research at this level has been hard. Nevertheless adopting a critical realist stance in research and applying it in this study has deepened my understanding of it and opened the door to future applications.

The journey continues. I have identified a number of topics for further research. I would like to explore the use of different perspectives in the DMP with other teams of practitioners and I would like to develop the attributes model further. I have shared this model with my colleagues in the educational psychology service and with clinical psychologists. Two practitioners intended to use it in particular situations and I would like to discover how useful they found it.
REFERENCES


Croskerry, P. (2003). The Importance of Cognitive Errors in Diagnosis and Strategies to Minimize Them. Academic Medicine, 78(8), 775-780.


DCSF. (2008d). Targeted Mental Health in School (TaMHS) - Background Annex C. Nottingham: DCSF.


DCSF. (2010). *Think Family Pathfinders: Research Update.* Nottingham: DCSF.


DfES. (2005). *Excellence and Enjoyment: social and emotional aspects of learning (guidance).* Nottingham: DfES.


Appendix 1 Participant Information Sheet and Consent Form

Working Title: Decision Making in a Multi-agency Team

Research – Thesis as part of my Doctorate in Educational Psychology

Helen Paton

Participant Information Sheet

You are being invited to take part in a research study. I am currently studying for a Doctorate in Educational Psychology at the University Of Manchester. I have completed three research papers and I am now at the stage of beginning my Thesis. Before you decide to take part in this research it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Who will conduct the research?

Helen Paton
Educational Psychologist
Doctorate Student
School of Education
University of Manchester

Title of the Research
Decision Making in a Multi-agency Team

What is the aim of the research?

The aim of the research is to study the decision making process in a Targeted Mental Health in Schools Team (TaMHS). In this case study the intention is to gather data in a number of ways to describe the process or processes of decision making that are in use, what differences and similarities exist between practitioners and how the process is linked to the evidence-based practice agenda. This might then indicate a practice model which could be useful for other teams. The findings from this research will be fed back to both EWiST (TaMHS) and IST over the next six months as part of the development of these Teams.

Why have I been chosen?

You have been chosen either because you are a member of EWiST (TaMHS) or because you are a member of IST or because you are part of the process of decision making (Cluster Group meeting participant).

I am hopeful that this process will be of use to yourselves as reflective practitioners and helpful in your professional development. I am also hopeful that the whole process will add to the development of the team.

What would I be asked to do if I took part?

Several members of EWiST, from each professional background, are going to be invited to take part in 2 Interviews of about an hour each. During the second interview I am going to ask the interviewee to talk about a case during which they
felt that good progress had been made. I will ask interviewees to use pseudonyms for any features of the case that may identify the child or their family. I will ask the interviewee if I can tape record the interview otherwise I will take notes. All members of EWiST are going to be invited to take part in a focus group (about an hour). I am going to run 4 or 5 Focus Groups based on professional background. I will ask for permission to record, but if not given I will take notes. I am going to feedback this information anonymised to both teams (EWiST and IST) and invite comments on the information I present and gather these comments for further analysis.

I am going to ask to observe one cluster group meeting. I will ask permission of those people who attend a meeting who are not members of EWiST or IST at least two weeks prior to the meeting.

**What happens to the data collected?**

When the data is collected on tape I will arrange to have it transcribed. I will use a code instead of your names to anonymise the data. I will remove any children’s names mentioned in error. I will input all the data collected into a programme which will assist my analysis such as ATLAS-ti. I will be analysing the data for themes which I will further analyse into conceptual models which I will share and discuss with all of you.

I may use direct quotes in my Thesis if these are identifiable I will check with the participant that it is acceptable to do that.

**How is confidentiality maintained?**

This is not part of your performance management as there will be no reporting back to managers of individual data. However if during an interview or a focus group any participant mentions something which suggests to me that they are putting themselves at risk or a child at risk through there work practice I will talk to them about this and if necessary (and only after telling them) I will inform their Line Manager.

I will keep the transcribed interview tapes and/or notes securely on my home computer in a password protected area. They will be anonymised by using a code to indicate who the interviewee is and the codes will be known only to me. I will destroy the tapes and data when my Thesis is completed. I will not use any names. I will only use anonymous quotes.

**What happens if I do not want to take part or if I change my mind?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason and without detriment to yourself.

**What is the duration of the research?**

The whole research project from beginning to the handing in stage will be approximately 12mths. The data collection period will run from February 2010 to July 2010. During this time you might be invited to be interviewed twice for an hour each time, in addition you will be invited to be part of a focus group for an hour. Thirdly I will feed back to the whole team during two team meetings. If you are a member of a cluster group but do not attend team meetings I will arrange an alternative session to feed back.

**Where will the research be conducted?**
I intend arranging interviews and focus groups at venues agreeable to participants – Wxxxxxxx Dxxxx or xxxx xxxx. The feedback sessions will be during Team Meetings and will be at the usual venues.

**Will the outcomes of the research be published?**

I will make available to all participants a copy of my Thesis. I will also produce a summary of my findings for circulation within the Department. At some point in the future I might produce an article for an Educational Psychology journal.

**Contact for further information**

Helen Paton 476576

Email address

**What if something goes wrong?**

If you have any concerns about this project please contact me:

Helen Paton 01253 476576

Email address

*If a participant wants to make a formal complaint about the conduct of the research they should contact the Head of the Research Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL.*

**PARTICIPANT CONSENT FORM**

If you are happy to participate please complete and sign the consent form below

Please tick

1. I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.

2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to myself?

3. I understand that the interviews will be audio-recorded

4. I agree to the use of anonymous quotes

I agree to take part in the above project

Name of Participant Date Signature

Name of Person Taking Consent
Appendix 2 List of Local Documentation

Local Documentation

1. Mental Health in Schools Project - Expression of Interest
2. Bxxxxxx Early Action for Change (BEACh) Quality Assurance Toolkit Manager's Guide to the Tools (CAF)
4. Common Assessment Framework Leaflet for Children and Young People
5. Common Assessment Framework Leaflet for Parents and Carers
7. Mental Health in Schools Phase 2 Final Version
8. Inclusion Support Team/ Emotional Wellbeing in Schools Team Meeting Minutes 03.02.10
9. Operational Group Minutes
Appendix 3 First Team Manager Interview Schedule

Decision Making in a Multi-agency Team
Semi-structured Interview Manager

Thank you for agreeing to the interview. Remind her that this is the first of two. Discuss confidentiality and that she can withdraw if she wants. Ask if I can record the interview and explain what will happen to the recording and transcript. If you use names of team members be aware that I will be having an admin worker in PH typing this up. I can ask her to remove them.

Firstly
- What is your job title?
- What is your professional background and training?
- Are you registered or equivalent to a Professional Body?

Team details
- Can I just check that I have the team members job titles correct?
- And their roles?

In this interview I would like to gather your description of the decision making model that EWIST are using.

Prompts:
- Cluster model
- Who are involved
- How are you involved with this process
- Team roles
- Expectations
- Gaps – of understanding
- Variability within team

How are decisions recorded?
- CAF and BEACH Action Plans and other ways?
- How is CAF working?
- Are they quality checked?

What interventions are offered?

Are there opportunities for reflection about decisions?
- Supervision

How are outcomes measured?
- SDQs
- Anything else

Evaluation - Are outcome measures tied into to intervention delivered?

What model of understanding of children’s circumstances underlies the team?

Thank you very much for your help and co-operation. Check that she is OK with the interview. Is there anything else you want to say or anything in it you are unhappy with? Remind her that I will send the transcript to her and she can check it. Explain that I will also come to the second interview with a brief summary of her views to check that I have captured them accurately.

Agree a second interview date.
Appendix 4 Interview Schedule 1

Decision Making in a Multi-agency Team Semi-structured interview 1

Thank them for agreeing to the interview. Remind them that this is the first of two. Discuss confidentiality and that they can withdraw if they want. Ask if I can record the interview and explain what will happen to the recording and transcript.

What is your job title?
How would you describe your job?
  • Professional background – education, health, social work, other
  • Training
Is your job registered or do you belong to a Professional body?
  • How does this influence the way you work?

How long have you been in the team?

Can you describe the decision making process - that is the process which takes place to decide what intervention or response to make when a child is brought to your notice?

Prompts:
  • Think of the last three meetings/referrals how was the decision made or
  • Think of two children one you worked with one you didn’t work with write their names on these cards don’t show me and discuss the process in relation to them.

Prompts
  • Who is involved?
  • Who has a final say – is it a shared decision, or an individual decision?
  • How is process recorded?
  • How do you find the CAF and Beach action plan?

I have used the word circumstances in my research question – that children and families and schools experience – what word or phrase would be most commonly used by you and those you work with?

Prompt:
  • Think of two children as above write their names on these cards don’t show me and in their cases how would you describe them.
  • Give me a couple of sentences to describe the children
  • Does this imply causation?
  • Beliefs about what next?
  • Long-term outcomes?

There may be many different circumstances – what are the most frequent circumstances you encounter?

Other people’s views of “circumstances”
  • How do you think the child would view the circumstances or situation?
  • How do you think the parents would view the circumstances?
• Would they use similar or different words or phrases to describe the circumstances?
• How do you think that the referrers (school staff) view the circumstances?
• Do you find that there are different views in the team?
  o Prompt: Imagine someone in the team in your head don’t name them how would they talk about this.

Has being part of this team changed the way you work or the way you think about your work?

Thank them very much for their help and co-operation. Check that they are OK with the interview. Is there anything else they want to say or anything in it they are unhappy with? Remind them that I will send the transcript to them and they can check it. Explain that I will also come to the second interview with a brief summary of their views to check that I have captured them accurately.

**Remind them about the second interview and agree a date.**

Ask them to come prepared with a case in their head which they believe was successful – could be improved SDQ scores or some kind evidence that they believe the case was successful. Explain that I am really interested to hear about cases that went well and that everyone has examples of work that they feel went well and its nice to talk about things that have gone well. I will not be gathering the information about the cases I just want them to use the case to help them talk about the choices/decisions made.
Appendix 5 Interview Schedule 2
Decision Making in a Multi-agency Team Semi structured interview 2

Thank you for agreeing to the interview. (Discuss confidentiality and that they can withdraw if they want). May I record the interview (and explain what will happen to the recording and transcript.) I will make sure that if by mistake you mention a child’s name I will remove it. Also I will remove any other identifying information from the transcript before analysis.

We talked last time about the decisions making process briefly and how you view the circumstances around the children that come to your notice. (Include in here a summary of their interview – they will have seen the transcript but use this time to check my understanding of their views)

Today I would like to ask more about the process and the choices of interventions for and around the child.

To help give this some structure I would like you to describe the process as it relates to the case which you have in your head.

Tell me about the case

Prompts if necessary:
- How you heard about the child?
- Who was involved?
- What were the concerns?
- What information did you need to gather to make a decision?
- How did you weigh different types of information – observational, tests, expert, present or past, family’s views child’s views?
- At what point was a decision made?
- By whom?
- Children, parents, school staff, other team members, others
- How certain were you or were decisions tentative?
- What interventions were agreed?
- Who delivered?
- Why this/these interventions?
- How was this evaluated
  - SDQs
  - What else?
  - How agreed?
  - Where recorded?
- What do you think made this intervention successful?
  - relationships

On reflection:
- Suppose that that particular intervention had not been possible - do you think the best decision was made?
- What happens to stop optimal decision making?
- What would you say was the difference between this decision process and one that did not work as well?

What are the available interventions that EWIST can:
- implement
- or access?

Who can deliver?
Do you know what other team members do?

Evidence – informed practice:

*Prompts:*
- How do you access information about what works:
- What have you read or accessed in the last month?
- Reflection – what opportunities do you have to reflect and how useful is this?
  - supervision
- Have you read the “what works” document?
- Does the team collect evidence from own practice and how does this inform decisions?

Thank you very much for your co-operation and help.

Check that they are OK with the interview. Is there anything else they want to say or anything in it they are unhappy with? Remind them that I will send the transcript to them and they can check it. I will also make sure that I check a brief summary of my view with them.

If they want to check anything out with me they are welcome to get in touch.
### Appendix 6 Cluster Meeting Observation Schedule

**Present**
**Not present**

<table>
<thead>
<tr>
<th>Time</th>
<th>Beg</th>
<th>End</th>
</tr>
</thead>
</table>

**General**

**Case:**
- New/Review

- **If new presented by:**
- **If review presented by:**

**What intervention taking place?**

**Co-workers**

**Any specific questions or requests of cluster meeting**

**Process**
- **Is a decision made in this meeting?**
- **What was the decision?**

- **Is this reporting back and no decision?**

- **Has a decision been made elsewhere?**

**Type of Information mentioned**

**Language used**

**Models mentioned or inferred**

**Interventions**

**Questions asked**

**Supervision/Reflections**

196
<table>
<thead>
<tr>
<th>NVIVO Function/Facility</th>
<th>How it works</th>
<th>My terminology/use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sources</td>
<td>The storage area for all data e.g.:</td>
<td>All sources can be accessed within NVIVO.</td>
</tr>
<tr>
<td></td>
<td>• Interview documents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Interview Recordings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• National and Local Documents</td>
<td></td>
</tr>
<tr>
<td>Free Node</td>
<td>Text is highlighted and then it is either assigned to a new node or an existing node.</td>
<td>Theme</td>
</tr>
<tr>
<td>Labels and Descriptions</td>
<td>Whenever a new node is created a box opens to ask for a label and a description.</td>
<td>Thematic Code</td>
</tr>
<tr>
<td>Tree Node</td>
<td>Nodes grouped together in hierarchies</td>
<td>Overarching theme and subordinate themes which make a thematic network</td>
</tr>
<tr>
<td>Highlights</td>
<td>In each source such as an interview it is possible to highlight all coded text or only text coded to one or more node.</td>
<td>This function was useful when rereading text and concentrating on one node to check for internal coherence and consistency.</td>
</tr>
<tr>
<td>Coding Stripes</td>
<td>When a source is open a selection of all or only some nodes can be chosen and the coding stripe runs alongside the text showing which parts are coded for which nodes.</td>
<td>This facilitated comparisons between nodes as overlap could be easily identified.</td>
</tr>
<tr>
<td>Matrix Coding Query</td>
<td>A box opens to allow the choice of different nodes (or other features) into two axes and then these are compared. Whenever text is assigned to both nodes then this is shown in the intersecting box in the grid which is produced.</td>
<td>This was another way to check for the coherence and consistency of coding.</td>
</tr>
<tr>
<td>Dynamic Model</td>
<td>This facility provides a drawing board with gridlines and a selection of shapes.</td>
<td>I used this function to experiment with different models.</td>
</tr>
</tbody>
</table>
Appendix 8 List of Interventions Delivered by or Accessed by EWIST

Delivered by EWIST: one to one child
- Generalised relationship building: usually based on the development of trust through confidentiality and a warm therapeutic alliance
- Building self esteem
- CBT as an underlying model to help develop understanding of situations and of possible ways of changing

Therapeutic Tools
- Art/craft materials
- Games
- Puppets
- Books
- Worksheets
- WHYTRY: Group or individual?

Delivered by EWIST: group work with children
- Around self esteem
- Anger Management

Delivered by EWIST: systemic around individual children with teachers and parents
- Use of assessment to help the adults in a child’s life to understand the child in a different way - to facilitate changes in the relationships with the child and new approaches with the child

Delivered by EWIST: systemic around individual children with teachers
- Behaviourist Programmes with teachers as implementers
- Improving quality of relationship teacher/pupil

Delivered by EWIST: systemic around individual children family support
- Identifying issues within families which are hindering the quality of family life and trying to access solutions for or within the family (housing, debt, substance abuse)
- Using BEACH money to pay for items to improve quality time in families
- Family mediation

Delivered by EWIST: systemic around individual children and parenting
- Using attachment theory as a way of understanding children and then facilitating through this understanding relationship work and behaviour management work with parents/carers
- Triple P Programme
  - Course
  - One to one – adapted as appears appropriate depending on family circumstance
- Strengthening Families Programme
  - One to one – principles and ideas used to improve relationships

Accessed by EWIST
- Using BEACH funding to pay for
  - A local therapeutic private sector service
    - Individual therapeutic work CBT
    - Group work
  - Play therapy delivered by a private practitioner
- Specialist CAMHS
- Intensive family support - Another local LA team
- Domestic Abuse Services – LA services
- Positive activities – LA service
### Appendix 9 Codebook Research Question 1 Cognitive Processes

<table>
<thead>
<tr>
<th>Name</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intuition “gut feeling”</td>
<td>Examples of gut feeling – something which is outside of conscious thinking</td>
<td>I suppose because you’re the one the goes into the school and collects that information, you do feel that you have more sense of what is going on for that family. (L1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>That’s a really difficult one to sort of accept that you are doing, because I think sometimes you do it unconsciously. Because like I said to you previously in the last session there are some things about your practice that you just do and I think that’s one of them. (L1)</td>
</tr>
<tr>
<td>Pattern Recognition “looks like”</td>
<td>Examples of saying it looks like and of recognising a situation as a certain type of problem or suitable for a certain type of intervention based on first or early impressions rather than an analysis of assessment or discussion process</td>
<td>No not everybody but there is always the possibility of that happening, particularly in the high schools. I can recognize it sometimes particularly one girl I have seen. I think she has gone from service to service and I am always wary thinking if we don’t do something now it’s so vivid. I can actually think in a few years time she will end up, she going to be admitted she’s going to go park ward because I she’s so very much like people I have nursed in the past on hospital wards. (K1)</td>
</tr>
<tr>
<td>Perspective “a lens”</td>
<td>Mentions of looking at a child through different lenses, perspective or from different professional backgrounds</td>
<td>I suppose that’s because I treat Psychology as a lens but don’t feel it’s the only lens. They might be equally true in their own way but part of the value of the multi-disciplinary team is to look through lots of lenses at the same time. (A1)</td>
</tr>
<tr>
<td>Restating</td>
<td>A list or narrative description of events or factors but no linking to causes or consequences or theory</td>
<td>He was described by school as being very aggressive and they were quite scared of him. He’s a big child. The other children were scared of him and the teachers felt slightly intimidated by him as well. He lived with his ….. there’d been a history of domestic violence and school just quite worried about him and Mum was losing control. (O2)</td>
</tr>
<tr>
<td>Analysis</td>
<td>Describes a sequence of events and factors and links to causes and consequences but no explicit linking to theory</td>
<td>I tend to take each one as it comes I think. For example this wasn’t the case but other cases if I know that they’ve got a diagnosis of ADHD or there are questions around ADHD, I have different things in my mind that I know I’m looking for. But I don’t have anything particular I’m just looking at what I’m seeing and the key things that I look for really are key triggers for the youngster and interactions between the youngsters and the adults in the room. That for me is my real priority and then I kind of work around that as well and looking at this I’m kind of picking the strategies that are being used in the classroom. (P1)</td>
</tr>
</tbody>
</table>
It's about getting that relationship with the child and getting them to trust you that you won't go running back to Mum. It's about having that sort of person there like xxxx who you can say look you know she's told me this in confidence and discussing it and saying what do you think would work from a parenting perspective. What do you think would work because I know the child and if xxxx knows the parents then you can work with them. (K2)

<table>
<thead>
<tr>
<th>Formulation</th>
<th>Developing formulations of presenting problems or situations which integrate information from assessments within a coherent framework, that draws upon psychological theory and evidence and which incorporates interpersonal, societal, cultural and biological factors. British Psychological Society Clinical Psychologists Competencies p.3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>But the upshot of it was that cognitively he had very very low on the WISC a very very low working memory score and he himself was saying things like he doesn't always remember things like instructions that member of staff have said to him and for any kind of lengthy expositions sort of an introduction to what our topic is going to be he has very little chance of remembering key bits of that. So I did a cognitive assessment first time around because there had been some question about learning difficulties I thought it was probably as well and then when in school had done it to actually look at the attainments as well so the second time I went back looked at his attainments what have we got there. (A2)</td>
</tr>
</tbody>
</table>

For me the little girl had elements of depression she had a negative thought pattern in thinking that everybody hated her but it's not really enough information until you've actually asked what the little girl's opinion is. (K2)

I think they needed an intermediary at that point I don't think it necessarily had to be me. The family feed back when we had the CAF review to see how things were going to close the case to us the family said to us that they actually felt if there hadn't been somebody then they wouldn't be in the place they are at that point. I think that's probably right because they had they had all got these feelings that they were thinking that nobody was listening to. They had not told anybody else how they were feeling and they didn't know how to how have those conversations. They just needed somebody impartial to sit there and be sort of the sounding board I suppose. I was a safe person in allowing them to say what they want to say now that doesn't say necessarily mean it had to be me. (L2)
## Appendix 10 Codebook Research Question 2

### Codes

<table>
<thead>
<tr>
<th>Overarching Models of Understanding</th>
<th>Name</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk and Resilience</td>
<td>58 references from 11 sources</td>
<td>Examples of explicit use of the words risk and/or resilience. Also descriptions of risk and/or resilience factors in their descriptions of the child and their circumstances. However this is not coded as biopsychosocial because there may be an element of within child factors but described as life events.</td>
<td>Loss of a parent maybe parents separating or a bereavement in the family or those sorts of things that we tend to have happen. (C1) I would always spend a lot of time with the class teacher looking at roots of issues in the classroom, but also in many of the cases that I work on we will know what's going on in the family situation. They have been exposed to domestic violence you know there has been something like that a major trauma or something so there could be something like that that's going on like bereavement you could list all these different things. (P1)</td>
</tr>
<tr>
<td>Systems Analysis</td>
<td>Examples of an explicit description of either or both the family and the school which includes an element of cause and effect concerning the child's circumstances.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family System 32 references from 9 sources</td>
<td>I also come across a lot of generational traits where that's how parents were parented so that's followed through. That's how they parent their own children and perhaps that's what's causing the problems that kind of rigid thinking within the family. (C1) Focussing around the issues with family member and things but also around her self esteem. Because that was particularly quite low because she was quite isolated. We decided to put in some after school</td>
<td></td>
</tr>
</tbody>
</table>
activities. The little girl as well that was decided at the CAF meeting because again she didn’t have much contact with friends outside of school so that was put in place for after school activities following xxx having passed away. Again all the routines everything went at home so we kind of reviewed a lot of those. (C2)

<p>| School System | He was very much sort of cosseted and nurtured through his late primary years and did reasonably well in tests and things as a result. There were some concerns about what’s going to happen when moved on to secondary school as there often is in primaries. Basically the school had acknowledged the fact that he needed more time than other children did to process things so basically there was a note to teachers to say give this boy some extra time when you’re asking him for responses or even for written responses because he processes slowly. (A1) I go through my observations the things that I've seen during the observation I see some examples of very good practice. I felt that the SSA was exceptionally good at working with the youngster and keeping him on task. I felt the class teacher worked well in support of this young man. (P2) | 30 references from 10 sources |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biopsychosocial</td>
<td>Examples of descriptions which explicitly mention the terminology - biological/psychological/social.</td>
<td><em>I would be quite happy understanding that anxiety from a kind of analysis if you like of the socio environmental pressures on the child and the way they were perceiving themselves and the pressures of the situation around them.</em> (A1)</td>
</tr>
<tr>
<td>6 references from 2 sources (1 person)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Model</td>
<td>Examples of the terms medical, ADHD, depressed, anxiety, disorder, or diagnosis. The linking of diagnosis with some form of treatment. Some of the examples are describing what other people think.</td>
<td><em>for me the little girl had elements of depression</em> (K1) <em>this particular child they said we're growing concerned about him because he's becoming more withdrawn and they said they didn't want to use that label but but they said we're not sure if he's depressed or not and I said right if that's something we need to discuss then xxxx can come in and ask the right questions and do the whole visit and speak to parents and see whether this is normal behaviour or if this is a change.</em> (O1)</td>
</tr>
<tr>
<td>46 references from 11 sources</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Within Child Factors

<table>
<thead>
<tr>
<th>Name</th>
<th>Definitions</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Constitution | Examples of within child factors which includes cognitive factors and also examples of terminology such as anxiety, sad, withdrawn and depression when seen as part of the child. | *because they think the child has a some sort of constitutional factor that is impacting on their emotional health and well being or their behaviour so for example they might believe the child is on the autistic spectrum for example and the other is a worry that there have been un addressed learning difficulties in school so a member of the team might come and raise concerns.* *(A1)*  
*I think they would probably just say this is a quiet child or a sad child or they would query whether is this child depressed xxx went in to do some work to see whether this is just the way this child was or is there anything underlying that's going on so I those situations it's good to have that mental health expert.* *(O1)* |
<p>| Cognitive    | References to learning difficulties or memory problems with the implication that there is a measurable within child difficulty. | <em>but the upshot of it was that cognitively he had very very low on the WISC a very very low working memory score and he himself was saying things like he doesn't always remember things like instructions that member of staff have said to him and for any kind of lengthy expositions.</em> <em>(A2)</em> |
| Trauma       | Examples of the use of the term and also examples were a violent event is described as a casual factor and linked to an effect on the child when they have witnessed it. | <em>yes those were the kind of things we weren't sure of and I think it became a bit clearer down the line that he had been involved well not involved but he was aware and witnessed.</em> <em>(O2)</em> |
| Self Esteem  | Examples of use of the term in the descriptions of it was mainly focused around raising the little |  |</p>
<table>
<thead>
<tr>
<th>sources</th>
<th>the circumstances and in the interventions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>girl’s self esteem but also giving her some time to talk about her family and getting to know her a little bit better, they actually produced a folder around I think it was called something like “all about me” or something. (C2)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Locus of Control</th>
<th>Examples of the terms locus or internal or external being used in relation to the source of problems.</th>
</tr>
</thead>
<tbody>
<tr>
<td>so there was a lot of externalization and all of that whereas the family were ok, I'm ok when I am at home, the school is a big problem and why are you not doing something about me so that was a very different take on life coz almost almost a dissociation of his own involvement with things. (A1)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attachment Theory</td>
<td>Examples where the term attachment or bonding is used explicitly and this follows through and is used as an explanatory model when describing the family.</td>
<td>I would probably go onto say when he was living at home, he wasn't fed, he wasn't clothed, he wasn't taken to school. There was no care there, no nurturing and this has led to him acting out within school and at home. He is having, with his auntie, temper tantrums. At school he is, abstract, very short attention span, fidgety, moving around the classroom a lot, shouting out. (L1)</td>
</tr>
<tr>
<td>7 references from 3 sources (3 people)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Definition</td>
<td>Examples</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Personal Construct Psychology</strong></td>
<td>Examples of use when explicitly linked to the term PCP.</td>
<td>My own preference would be to try and look at this from a personal construct point of view with the child involved. (A1)</td>
</tr>
</tbody>
</table>
| **Behavioural Theory as an Explanatory Model and to guide Interventions** | Examples of explicit use of the terms: behaviourism, behaviourist, behavioural and also an analysis of behaviour or intervention which uses the terms such as rules, routines, star charts. It is often embedded in explanations which are more from social learning and cognitive-behavioural approaches. | OK someone approaches me with a situation about a child. Structures that I would use to understand the situation would be trying to move to a more precise understanding of what it is the child is doing or not doing so that if you wanted to put some sort of theoretical label on it I suppose being quite behaviourist about it at that point quite often I'm not clear what the concerns are by encouraging people to state them in that way helps me to be clearer about what the concerns are. (A1)  

... a behaviourist approach .... in a lot of ways yes it is it's kind of let's put some structure clear boundaries lets work towards this and repeat the same lets track it so it's very much along those. (C1) |
| **Social learning**               | Examples of the use of social learning and also the mention of relationships within the context of family or classrooms as being the basis of an intervention. As parenting programmes are based on social learning theory this includes mention of programmes. Sometimes the same text is coded both as behaviourist and social learning when both strands are mentioned. | I think probably the sessions I've done with Mum and the child together and the negotiating part because that's opened up communication channels for them they're able to talk now more and I think just the fact that they spend more time together and enjoy each other's company doing something positive has actually clicked lots of other things into place and that's actually helped the behaviour because the little girls got a more positive relationship with her Mum now. (C1) |
| Cognitive Behavioural | Examples which use the term CBT and also when there is an explanatory model about the child and family which includes besides behavioural factors a cognitive element. | yeh I think yeh she was jumping to conclusions really thinking they treat my little brother better than me ......but it was her misinterpretations of situations really ....but I actually sat her down and got her to understand that some people don't find it easy to say I love you. (K2) |

<p>| <strong>Overarching Theme 2: Interventions</strong> | | |
| <strong>Name</strong> | <strong>Definitions</strong> | <strong>Examples</strong> |
| Eclectic | Examples of a practitioner using more than one approach in their direct work around a child - with child, family or in school. Not examples of work delivered by two practitioners. | If I had to put one name to it would be family mediation I think there was some low level family therapy there was a bit of solution focused therapy there probably a little bit of CBT in there as well but generally it was about family mediation it was opening the lines of communication because they had all painted themselves into corners and got stuck and didn't quite know they needed somebody there just to facilitate the conversation that they were all yeah. (L2) |
| Solution Focused | Examples of use of the term solution focused and SFBT (Solution Focused Brief Therapy) and also descriptions of interventions which focus on solutions as opposed to explanations as to why something is happening. | yes then like I say after the Christmas I suppose it did go to the solution focused and then as things changed yes it was about unpicking it all really. (K2) |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Definitions</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maslow’s hierarchy of need</td>
<td>Example of an explicit use of this model and by the same Interviewee mention of working with one set of needs before another in a hierarchical fashion</td>
<td>yes but sometimes actually I go a step further back than that where I would probably put in what I would call more family support work so maybe I’m looking at the housing situations really unstable or something like that that makes that families’ situation really quite vulnerable at the moment. (C1)</td>
</tr>
<tr>
<td>Goal based</td>
<td>Examples of the use of the term - goal.</td>
<td>I project where we’d like that family to be I think it’s very ongoing actually I probably have some short term goals in mind we perhaps have some longer term goals. (C1)</td>
</tr>
<tr>
<td>Person Centred</td>
<td>Examples of the use of terms related to a person centred approach</td>
<td>I suppose it goes back to the non judgmental stuff I am here to help you it’s your family you know what you want I am here to help you to. (L2)</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Examples of use of the term and examples of developing skills for the future so the individual can cope without support.</td>
<td>I give her the skills to actually cope with anything that may come up at a later date and with him as well in the same way. (L1)</td>
</tr>
</tbody>
</table>
### Appendix 11 Codebook Research Question 3

<table>
<thead>
<tr>
<th>Code</th>
<th>Name</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child or Young Person’s Views</td>
<td>A decision taking into account a child or young person’s view or willingness to work on a particular aspect or in a particular way.</td>
<td>For me valuing the parent and the young person, if the young person’s present and fully involving them in making appropriate decisions. (P1) School were kind of as well, we don’t know where to go we don’t know what to do. So I did do some anger management work with him because that’s what he identified that he lost his temper a lot. (O2) For me the little girl had elements of depression she had a negative thought pattern in thinking that everybody hated her but it’s not really enough information until you’ve actually asked what the little girl’s opinion is. (K2)</td>
<td></td>
</tr>
<tr>
<td>Parent’s View</td>
<td>A decision being based on or taking into account the parent’s view or particular needs.</td>
<td>And had a chat to school about it Mum felt she’d like some support at home, so that’s what decided to put in. (C2) I would say the joint working is a massive factor and has a massive impact because if you’ve got parents on side and you’ve got the child on side and they’re both willing to change then you know you’re half way there, before you’ve even started really. (K2) Yes so at that point with all the information we needed families’ agreement to that so the behaviour advisory teacher who’d had all the contact with the family arranged a CAF meeting. At that CAF meeting with school and mum and the girl and myself and the behaviour advisory teacher we talked about ways forward and family agreed to me doing some family work with them. (L2) ...interestingly after all that parents also came up with some things that they felt they could chime in with for the whole intervention program. (A2)</td>
<td></td>
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</tbody>
</table>
| School's View | A decision is based on what the school thinks should be the area to work with usually it would not be the deciding factor on its own. | In actual fact I always make sure it's an agreed list of strategies that are going to be tried if you like so that there made doable if you like so an achievable HP – for that teacher and that situation? Absolutely because if you don't have that you're not likely to get change are you? If it doesn't feel right for them. (P2)  
SENCo wasn't there but the assistant SENCo and his pastoral head were there as well so it was very much a collaborative planning meeting. In the sense that what I did on that day was to outline the findings and then said something like if you look at the literature on difficulties of these kinds these are the sorts of things that can help. What I need now to do with such as the teaching staff in the room is see how feasible these are and what we can turn into practice for him in school. (A2) |}

| Therapeutic/ Collaborative Relationship | The concept of developing a working relationship with the child, family and/or school staff in order to deliver an intervention effectively and if not present then it can stop an intervention. | HP - As a kind of fundamental to what was going on there was a good working relationship? Yes definitely I think it took quite a bit of time to build it up with Mum actually for her to actually open up and start being honest she was very guarded when I first met her but slowly but surely over the weeks and months that I’ve worked with her that’s finally fallen into place and I think she quite trusts me now. (C2)  
Yes it was a really positive teacher to be working with so that kind of is the format that each of the strategies that we talked around. I’d bring something to the table and then we’d backwards and forwards suggestions or tweaking it to make it right for her environment. (P2)  
But at the moment everybody is saying this is the issue, no other issues have been brought up so we wouldn’t make anybody work with something that they don’t want to work with. |}
| Data | This can include information from school staff and/or families, assessment and observation. | Then trying to blend and synthesize that with the information the EWIST team had collected so that would be understand what was going on in the CAF. Understanding things like the SDQ information and then thinking where that synthesis got us in terms of a formulation. (A1) |
| Beliefs or Theories | Examples of the practitioner basing a decision on an underlying theory or belief relating to the child and their circumstances | The sort that I’ve just given you so there were questions about learning difficulties in school and understanding in class. Could she have my view on what we might be doing as a team to look at that side of things because there’d already been this sort of quick route to CCATS to look at the anxiety? So it was established that the questions to me weren’t about the manifestation of anxiety in school they were about these other issues, so we then had a conversation about learning difficulties. (A2)  

Certainly when Grandma passed away Mum became quite depressed. I think not having anybody to speak to or to sort of support to look to the future because I did quite a few practical things with her like finding information from college. She certainly seemed to need that little kick start to get going. So yes I think they probably would have been remained in the isolated place that they were because Mum didn’t seem to have the skills to find a
<table>
<thead>
<tr>
<th>Skills</th>
<th>These are references to the availability of skills within the team or in another team which helped to decide the choice of intervention</th>
<th>In that sense I think there is an optimal process happening already that people are aware of the constellation of possible input of team members and go and seek them out as needs be. (A2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint working with Team Member</td>
<td>References to working with another team member which has been a crucial part of deciding the course of the work with child and family</td>
<td>I think there’s three cases where xxx does the parenting and I’m working with the child and it’s worked really well. That myself and xxx have discussed it afterwards and said right what happened with your session with the parents and I’ve said what’s happened at home and we’ve discussed it and planned a new tactic to use. (K2)</td>
</tr>
<tr>
<td>New Information – subsequent events</td>
<td>References to new information or subsequent events arising once work is underway</td>
<td>I think it was quite soon after or otherwise they might have rung us because they do ring if this happens. Yes there was a really violent incident nobody could really get to the bottom of why or what. I don’t think the boy himself really knew how it had got to that stage so we came back and discussed that. (O2)</td>
</tr>
</tbody>
</table>

HP – right ok so the next crucial time was the point at which thought right maybe one to one work for the wee girl I - .....I picked up the information from |
<table>
<thead>
<tr>
<th>Blocks</th>
<th>Staffing Levels</th>
<th>Lack of or poor quality information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mum that Grandma was becoming more unwell. That the family was becoming more chaotic because everyone was trying to get involved in the care. (C2)</td>
<td>I'd say staffing levels. I would love like I say I've got six seven cases in xxx which isn't my cluster and I'm in the xxx cluster and I would love to be working with more children. (L1) I am not sure it isn't optimal already in the sense that we have a team with a high throughput of cases who are themselves very time pressured. So I think what happens in a situation like that is that people will make judgments about the most urgent needs and go and seek professional help to illuminate those needs and do something about them. (A2)</td>
<td>The decision will be go away and get some more information as we can't make an informed decision about this. (L1) In this case Mum was quite honest but you never know there might be something else that you don't know there could be a piece missing. You can't deal with that if you don't know. (O2) Sometimes as well it's about the school's understanding of what's necessary as well because we don't always get the information we need from schools. (L2)</td>
</tr>
<tr>
<td>References to level of staffing in team affected by illness or other factors stopping or affecting decisions</td>
<td>References to the lack of a piece of information or poor quality of information (hearsay) affecting or stopping decisions</td>
<td></td>
</tr>
</tbody>
</table>
| Initial lack of co-operation from parent or teacher | Examples when families or teachers have not been co-operative in the initial stages and this has led to different decisions | It's whether everybody’s on board. We worked with another boy in the same year at the same school and that didn't work because mum wasn't on board. Didn't want any support and the little boy he was just a bit I don't think he was that bothered about what we were doing. (O2)  
Sadly I've been recently to another school where I felt I’ve broached this situation exactly the same way. Yet it was quite clear I think the teacher might have felt a little threatened by me and was almost like paying lip service with some of the ideas. As much as I was trying to push back say well this is going to work for you you tell me what is going to fit in your class. You know all of that and I returned and upon review maybe one of them (strategy) that he'd even attempted and the others very quickly dismissed and barely continued. (P2) |

| Lack of specialist skills | Where specialist services are not there like speech and language you know. They are things we battle against all of the time there's a real need and those things are not covered maybe. I suppose we have obviously got the EPs but I know there's specific learning difficulties and things like that sometimes you know aren't there so more staff or maybe more specialist would be we are only tier one again so it's the tier two. (O1) |
## Appendix 12 Thematic Analysis Quality Checklist

<table>
<thead>
<tr>
<th>Process</th>
<th>No.</th>
<th>Criteria</th>
<th>My research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transcription</td>
<td>1</td>
<td>The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for ‘accuracy’.</td>
<td>Interviews recorded transcribed and checked against tapes for accuracy</td>
</tr>
<tr>
<td>Coding</td>
<td>2</td>
<td>Each data item has been given equal attention in the coding process.</td>
<td>All data items thoroughly read, reread and coded</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.</td>
<td>The process has been thorough, inclusive and comprehensive</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>All relevant extracts for all each theme have been collated.</td>
<td>Codebooks have been produced for each theme</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Themes have been checked against each other and back to the original data set.</td>
<td>As described in the methodology chapter I used functions on NVIVO to help me in this process. I also asked for participant feedback at a number of staged through the process. I also tried different arrangements and sorting on paper.</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Themes are internally coherent, consistent, and distinctive.</td>
<td>As described in the methodology chapter I used functions on NVIVO to help me in this process. I also tried different arrangements and sorting on paper.</td>
</tr>
<tr>
<td>Analysis</td>
<td>7</td>
<td>Data have been analysed - interpreted, made sense of - rather than just paraphrased or described.</td>
<td>I have gone beyond simple description and interpreted the data and produced models</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Analysis and data match each other - extracts illustrate the analytic claims.</td>
<td>The participant checks to some extent provide support for my interpretations</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Analysis tells a convincing and well-organized story about the data and topic.</td>
<td>I believe I do tell a convincing story. There are, I also believe, further stories to extract from the data and someone else starting from their viewpoint could have told a different story.</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>A good balance between analytic narrative and illustrative extracts is provided.</td>
<td>I have tried to use quotes and models to illustrate but not dominate the narrative.</td>
</tr>
<tr>
<td>Overall</td>
<td>11</td>
<td>Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.</td>
<td>I was very thorough. The NVIVO software was more efficient compared to post it notes stuck to walls in my house but I still spent a long time going over and over the data as shown by the 8 rounds of analysis.</td>
</tr>
<tr>
<td>Written report</td>
<td>12</td>
<td>The assumptions about, and specific approach to, thematic analysis are clearly explicated.</td>
<td>I believe so</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>There is a good fit between what you claim you do and what you show you have done - i.e., described method and reported analysis are consistent.</td>
<td>I believe so</td>
</tr>
<tr>
<td>14</td>
<td>The language and concepts used in the report are consistent with the epistemological position of the analysis.</td>
<td>I believe so</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>The researcher is positioned as active in the research process; themes do not just ‘emerge’.</td>
<td>By giving my viewpoint explicitly on a number of occasions and showing the way I have approached the data I think I achieved this</td>
<td></td>
</tr>
</tbody>
</table>