Social workers in multidisciplinary teams: issues and dilemmas for professional practice

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ABSTRACT

This paper draws on the findings of a project, funded by the Economic and Social Research Council of the UK, examining how child and family multidisciplinary teams learn and work together. It outlines the approach taken by the research team before going on to explore New Labour policy around 'joined-up thinking'. The paper focuses on the role of social workers in the teams and uses qualitative data to explore the experience of social workers in relation to four key issues: models of professional practice, status and power, confidentiality and information sharing, and relations with external agencies. We argue that these are complex and contested issues that are challenging for the workers concerned. We conclude that whilst joined-up working is complex and demanding, social work is well situated to meet the challenge, and that social workers in multidisciplinary teams are committed to making them work.

INTRODUCTION

This paper draws on a project funded by the Economic and Social Research Council of the UK known as MATCh (Multi-Agency Team Work in Services for Children), based at the University of Leeds, UK. The project aimed to investigate the reality behind the rhetoric of 'joined-up thinking', a government priority in reframing services for children and their families and central to the thinking behind the Children Act 2004. Here we reflect on the experiences of the social workers based in the sample teams. Four of the five multi-agency teams we researched had social workers within the team. The teams comprised one with a youth crime focus, a community-based team working with young people with emotional and behavioural issues, a health-based team working on child development issues, another health-based team working with children injured in accidents, and a special needs nursery team, which did not have a social worker as a member.

The objective of the research project was to reflect on the perspectives and experiences of professionals about the impact of multi-agency teamwork on their professional knowledge and learning and on their ways of working.

METHODS

The research project was a qualitative, multimethod study involving three phases. Phase One included gathering documentary evidence from the teams and observation of their team meetings. Phase Two consisted of interviews with team members to explore issues arising from analysis of evidence from the meetings and documentation. Phase Three involved team members in focus groups responding to vignettes based on critical incidents from their workplaces around decision-making and knowledge sharing. The interview and focus group material was analysed using NVivo software. We also held a formative feedback session with representatives from all five teams. The multimethod approach allowed us to explore the complex interplay of both structural systems related to employment and line management and participants' professional affiliations and personal feelings.

POLICY CONTEXT

The 'New Labour' government, elected in 1997, had a stated commitment to the idea of joined-up thinking as central to the reform of welfare services. The policy aims to improve the effectiveness and efficiency of public services and to acknowledge the interrelated nature of family and children's needs in the fields of health, social services, criminal justice and education.

There are many examples of joined-up policy initiatives that are relevant to social work, including:

- the Children Act 2004, and the preceding Green Paper, *Every Child Matters* (Department for Education and Skills 2003);
- in health the White Paper *Saving Lives: Our Healthier Nation* (Secretary of State for Health 1999), and the NHS Plan (Secretary of State for Health 2000);
- in social services the White Paper *Modernising Social Services* (Secretary of State for Health 1998);
- in criminal justice the Crime and Disorder Act (The Stationery Office 1998);
- in day care and education *Meeting the Childcare Challenge* (Department for Education and Skills 1998b) and the White Paper *Meeting Special Educational Needs (SEN)*: *A Programme of Action* (Department for Education and Skills 1998a).

It is clear from these documents that joined-up thinking forms a major part of New Labour discourse around the modernization of public services. We see joined-up thinking as a shift in conceptualizing professional work with children and young people, although this builds on the familiar themes in social work practice of 'working together'. Despite the policy emphasis on joined-up thinking there are few conceptual frameworks for setting up, managing and delivering joined-up services. Often professionals have simply been exhorted to initiate multi-agency working with little training or guidance (Anning & Edwards 1999) and the processes by which new ways of multi-agency working will deliver services have scarcely been theorized (Easen *et al*. 2000; Atkinson *et al*. 2001). Evaluations of emergent models are often at formative stages: for example, centres of excellence (Bertram & Pascal 1999; Anning 2001), child mental health (Cottrell *et al*. 2000), Sure Start (National Evaluation of Sure Start website, http://www.ness.bbk.ac.uk), youth justice (Coles 2000) and special educational needs (Dyson *et al*. 1998).

An exception to this under-developed approach to implementing joined-up thinking is that of child protection, where there is a long history of thinking about and operationalizing what is usually thought about as 'working together' (Hallett & Birchall 1992; Birchall & Hallett 1995). The report into the death of Victoria Climbié (Lord Laming 2003) has contributed to the thinking behind the Green Paper *Every Child Matters* (Department for Education and Skills 2003) that recommends universal services for children, improving information sharing between these services and developing a common assessment framework. Children's trusts are being trialled to provide the local authority-based infrastructure that reflects joined-up thinking in action. This stream of thinking is reflected in the Children Act 2004.

Our research focused on professional work and how professionals communicate, work and learn together. We would argue that joined-up thinking has profound implications for the concept of professionalism and how we think about professional knowledge and practice. It can be argued that traditional claims to professional expertise are based on developing expertise in specific professional fields, the antithesis of joined-up thinking (Frost 2001). In multi-agency teamwork, professional knowledge boundaries can become blurred and professional identity can be challenged as roles and responsibilities change. Such changes can generate discomfort, anxiety, and anger in team members as they struggle to cope with the disintegration of one version of professional identity before a new version can be built. Moreover, the rapid pace of reform leaves little time for adjustment. Distinctions between specialist and generic work within the teams are often being made as teams begin to move (often within tight time scales) from strategic planning to operational implementation, with little time for joint training (Hallett & Birchall 1992; Birchall & Hallett 1995).

There is little research evidence of how multi-agency teams are changing their ways of working, though there is a relevant body of research on multi-disciplinary work in health care, which is transferable to other fields. For example, Ovretveit (1993) describes four organizational types of 'formal teams' (fully managed, coordinated, core and extended, and joint accountability) and alternative methods of working such as 'network associations'. Onyett *et al*. (1994) find that implementation rather than conceptual issues causes most of the difficulties with multi-professional teamworking. However, we found little in the literature on the processes of decision-making in the delivery of welfare services, other than Engestrom's (1999) work within the field of activity theory.

THEORETICAL FRAMEWORK

Our research draws on two major theoretical frameworks – 'communities of practice' (Wenger 1998) and 'activity theory' (Engestrom 1999). In our search for theoretical frameworks embedded in research on the world of work we found socio-cultural theory helpful in that it encompasses both structural/contextual and psychological/interpersonal domains of knowledge. A key concept is a 'community of practice' (Lave & Wenger 1991; Chaiklin & Lave 1993; Wenger 1998). Wenger and associates argue that knowledge is produced in communities of practice in the context of practice. Some is conceptual knowledge brought into the situation from training and applied to the world of work. Some experiential knowledge is based on daily working routines. Because the knowledge is embedded in action, it is often tacit, rather than explicit.

In Wenger's (1998) model new knowledge is created in communities of practice by the complementary processes of participation (the daily, situated interactions and shared experiences of members of the community working towards common goals) and reification (the explication of versions of knowledge and rules into representations such as documentation or artefacts).

Practitioners from different disciplines are not usually expected to justify the conceptual base of their actions or interactions with clients in single-agency settings. In a multi-agency team differences potentially 'collide' as boundaries around specialisms are broken down. At this point, implicit knowledge must often be made explicit. Professionals have to find a common language to make knowledge accessible to their colleagues from other disciplines. This may involve discarding specialized vocabularies, which can be a painful process. To understand these processes, we drew on Engestrom's (1999) activity theory model in the field of knowledge creation and exchange. An important premise in Engestrom's model is that conflict is inevitable as tasks are redefined, and redistributed within changing organizations and teams. His premise is that such conflicts must be debated openly, as communities/teams come together with different knowledge, expertise and histories to pursue a common goal, if progress is to be made towards creating new forms of knowledge and practice. In order to effect change, team members must work through processes of articulating differences, exploring alternatives, modelling solutions, examining an agreed model and implementing activities (Engestrom 2001).

We have found these frameworks useful in understanding the working of multi-agency teams. Our research focus was on activities in the workplace, with language used as a lens through which to view knowledge exchange and decision-making about action.

THE SOCIAL WORKER IN THE MULTIDISCIPLINARY TEAM

The main aim of this paper is to draw from our data in relation to social workers based in multidisciplinary teams in order to reflect on their role in such teams and the implications for social work practice in these increasingly dominant settings. We focus on four key issues:

- Models of professional practice
- Status and power
- Confidentiality and information sharing
- Relations with external agencies

Each issue will be explored in turn before we draw provisional conclusions for the practice of social work in multidisciplinary teams.

Models of professional practice

Among the professions that work with children and young people there are a wide range of shared and diverse models of knowledge and practice. We wish to explore some of the tensions that arise between differing explanatory models, such as 'social' and 'medical' models. In this section we explore the core beliefs which social workers wish to maintain and those beliefs which might be modified when working with other professionals.

Differing core professional models

Different issues emerge in our teams relating to the mobilization of explanatory models. In the team concerned with youth crime a main explanatory difference arose between an emphasis on the young person's wider social and family context and a competing focus on the impact on the victim/complainant. The former model predominated in the social work-related professions whilst the latter model was predominant amongst the law-related professions. During our fieldwork a concrete example of this arose over a proposed trip abroad for young offenders which polarized positions within the team. We shall examine this in some detail as an example of the main theme of this section – a clash between different professional explanatory models.

This incident is outlined by a drugs worker as follows:

> 'And there was a great deal of tension amongst quite a few workers about why these young people should be treated to a trip to Disneyland in Paris for the Christmas period . . . how do you work and maintain a professional capacity to endorse something you don't actually believe in?'

The team manager, from a social work background, reflects as follows:

> 'People would have their views and it flares off every now and again; it did last time in terms of treats for kids.'

A number of colleagues in the team were very hostile to the idea of young people being taken away. Differences underlying this clash were referred to by the police officer:

> '. . . being a police officer, certainly in some of the team meetings, they don't seem to think about the victims. I get this feedback sometimes from my colleagues and it's all about the young person, I know they have a lot of issues but sometimes I don't think they speak about the victims and the complainants . . . I give my view, a balanced view.'

Reaffirming core values ('a balanced view') in the face of incommensurability is possible in a team culture which supports and encourages 'living with difference', which this team seemed to do. Engestrom would identify this as a crucial element in how teams construct the objects of their activity. This recognition and acceptance of difference emerges as an important skill in the multi-agency teams. But in the long term, according to the youth support worker, some practitioners can alter their attitudes over specific practice. The changing of attitude results from a series of clashes over time between specific professionals, for example in this setting as reported by a youth support officer, social workers and probation officers with differing views on whether or not specific young people should be breeched for breaking the conditions of legal orders:

> 'Difference in beliefs seems to have come across more, I would say, with the Social Work and Probation. You can tell who's who. Dead easy. You could tell your Social Workers because they'd sit down and they'd go, what's been going wrong and what can we do to get you back on track now, and your Probation Officer would be there going right the breech is in and they both . . . one's hardened the other one up and one's softened the other one up over the period of time. The breech, your Social Workers because they were so client centred really didn't want to and really didn't like breeching and your Probation Officers because they were so sort of public safety were, it's in the public's interests and this is the rules, these are what we have to follow and they weren't as flexible.'

Social workers and probation officers, sharing offices and managing cases, might to some extent re-evaluate models of practice vis-à-vis 'breeches', thus confirming Engestrom's (1999) premise that change occurs through open debate. Both professional groups subscribe to a social model, though there is a difference in terms of how they categorize offenders. The social workers apparently apply a stronger social model than others in the team. More far-reaching differences might emerge over other issues, and between professionals applying more differentiated models, as seen in disputes between social workers and police. The debate over 'treats' apparently revealed a fault line in which social workers were isolated, according to a youth support worker:

> 'Let's put it this way I think it was only the Social Workers that said they should be allowed to get something but . . .'

A probation officer summed up the divide:

> 'I've got one or two on my side! I think sometimes Probation are a little bit on the police side. Certainly ones up from the Social Services background tend to focus on the young person's problems.'

Thus the youth crime field appears to be a test bed for exploring professional development and knowledge sharing in an environment encouraging diversity and different levels of commensurability of professional values. While incompatibilities are noted, and persist, there is also evidence of common ground being valued, and of beliefs and practices altering under pressure of competing arguments and shared experiences of practice. The fact, for example, that the police officer and social worker report positive working relations, despite differences, indicates that teams as communities of practice (Wenger 1998) can evolve cultures allowing for the containment of difference, and supporting the possibility of professionals modifying their practice models at varying levels of depth. Joined-up working does not necessarily mean doing away with difference.

In the other teams differences emerged in different ways as we shall see later. In a health-based team, for example, the main difference was perceived by the social worker to be between the dominant medical model and what she perceived to be the subordinate social model. We perceive the medical model as focusing on issues of health and illness, with an emphasis on the individual. The social model takes a wider perspective and places more emphasis on the social context in which the individual lives. One social worker expressed this difference as seeing her role as being

> 'to look at the family as a whole not just as a medical model of being well, but to look at the child and family as someone who is needing more than just to get physically well.'

At a community-based support team, working with children with emotional and behavioural difficulties, tensions arose due to competing intraprofessional strands within a dominant psychological health model. The nature of tensions between professional models is specific to particular situations.

Underlying these variations a common theme is the challenge for professionals in multiprofessional, multi-agency teams to contain and embrace diversity while not sacrificing those beliefs which underpin their commitment. Professionals are challenged to reflect on which beliefs about practice are imbued with core values, and which can be modified through the development of new forms of knowledge within the team, which form the basis of a 'shared repertoire' (Wenger 1998).

In practice, sometimes the reflection on the use of explanatory models for understanding professional difference is very explicit. In the following example a social worker reflects on the impact of differing models in terms of access to a building:

> '. . . they [the medical staff] are used to it and they work within it but it's not very user friendly for someone who has mobility needs themselves, it's not the most user friendly building and I think that's the difficult difference within a medical and a social model. I'd say it should be accessible to meet everybody's needs.'

In one of the health-based teams, the main dilemma of competing models arose for the social worker. Her problems included a belief that some consultants in the team environment did not understand her employing agencies' procedures, and a belief that some of the consultants did not facilitate her involvement with the team. For example, the social worker felt that the consultants sometimes blocked referrals to her agency because they could not see the *value* of the work she could facilitate:

> '. . . sometimes that is blocked though, and I think that is just because there is an inability to recognize the value of that work really.'
>
> '. . . I can clearly see which Consultants would use a Social Work service wisely and which wouldn't get the benefit of the services because they wouldn't make the referral.'

The dilemma of working for a marginalized agency in a team located within a different agency could be linked to professional models, rather than to information deficits, if the medical professionals' 'model' of social work deterred them from seeking a better understanding. This process is essential if a community of practice is to build a 'joint enterprise' (Wenger 1998).

Some issues raised by the social worker have to do with exclusion from the developing culture of a team. A circle of exclusion is implied, where belonging to a different agency precludes access to cycles of knowledge exchange and development, which would give the team better understandings about the agency. Accounts of consultants not being prepared to modify language, not speaking non-technical language, and lacking 'patience' to clarify meanings, revealed a hospital social worker's sense that attitude factors, stemming from differences of professional culture, are impediments to collaboration:

> 'I found it very hard to go in to that . . . meeting. And if I was a less experienced worker, I would find it extremely daunting. What is daunting is we don't even speak the same language . . .'
>
> '. . . lack of patience because they do know that I don't know things because I constantly try and express that, to the point where I get quite embarrassed about it really at having to repeat myself so often . . .'
>
> '. . . I once expressed that in front of the whole group. The doctor who is speaking said "oh okay" and then immediately didn't give a diagnosis for the rest of the meeting.'
>
> '. . . When the Psychologist joined the team he asked me about the integrated needs assessment, I went through an assessment with him, and he was quite interested in the resources that I could offer. He appeared quite eager to make referrals, but he didn't make any . . .'

Some of these barriers were linked by the social worker to her sense that not all health professionals understand the range of services that social services can offer. If there is a hierarchical *attitude* of undervaluing social services or misunderstanding professionals' expertise, that would not suggest fundamental incommensurability. It suggests a need for joint training and co-practice, and also raises questions about how different things might be under a common agency.

Status and power

In this section we examine issues and dilemmas around the distribution of power and status between different professions and how this impacts on practice and decision-making. This debate underpins the issues about 'models' which we have explored above. Wenger (1998) is keen to point out that by utilizing the phrase 'community' we should not assume that teams are sites of equality and shared power.

It is often difficult to unpick issues relating to power and status and those relating to personality – we can, however, perceive emergent patterns. Respondents discussed several dilemmas where status or personality clashes, or both, caused distress. Different professions might set a different value on status differences, and in multi-agency teams this could be a factor in some of the different clashes between professionals. At a health-based team, for example, the psychologist claimed to have noticed no status issues:

> 'But in terms of status things or somebody having a different view on how things should be managed, I haven't encountered that yet.'

In contrast the social worker in the same team was very preoccupied with what she saw as some medical professionals' overvaluing of their own status:

> 'I think the barriers are the status of different professionals.'

The social worker felt aggrieved that some consultants seem to think highly of their status whereas she claimed not to be overawed by her status as the most experienced social worker in the hospital social work team:

> 'I am not overawed by working with people just because they have got a tall hat on, but a lot of people are, and I think a lot of people with tall hats are overawed by their own status as well. And so I think one of the barriers is that sometimes people aren't listening to each other in that meeting.'
> '. . . But I think that in the hospital there is still the old, I don't know, you see "doctor in the house" films don't you, where everybody is following the consultant, scuttling on the ward rounds, and the consultant is shouting at the lesser mortals to do what they want them to do. It is not like that really now, but it still goes on . . .'

At another health-based team, the social worker, like her peer at the team discussed above, appeared unwilling to put consultants on a pedestal. Working alongside paediatricians dissolved any awe she may have felt, replacing it by a respect for expertise:

> 'It's broken down a few barriers as well as, you know like working with paediatricians, the way they're perceived perhaps by the general public, you know, they're just another profession to me . . . I don't feel the need to put them on a pedestal, they're down to earth like everyone else in the team and that's not an issue for me. I think it's having the knowledge of the work they do and working alongside them.'

Here the experience of joined-up working replaces stereotypical perceptions of other professionals with 'real life', everyday relations of respect and understanding which are specific and situational.

Teams where members have seconded status face dilemmas in sustaining an inclusive community. The youth crime team, for example, had permanent members (e.g. social workers) and seconded members (e.g. a nurse, probation officers). The challenge with seconded employment is, according to the team manager, to 'manage the change'. Team members were asked to adopt more generic roles or redefine their specialisms while passing skills to other team members, which was difficult where staff rotated frequently.

Some teams were characterized by core–peripheral membership relations, for example having the majority of professionals employed by health and a small minority by another agency (e.g. social services). Some members were also part-timers (including social workers). A danger was that peripheral members' dilemmas would not be heard. One psychologist acknowledged that

> 'all the core members have a voice and I think we do it together. But some of the people who only come in for two sessions a week may not feel like that because they're much more on the periphery.'

A nursery nurse also felt 'sort of peripheral' due to part-time arrangements and low professional status, while a social worker saw herself as non-core partly because of working in a separate building, and having restricted time with the team.

Where teams are perceived as having core and peripheral members, mutual understanding of roles was seen as very important. This understanding had been facilitated in two of the teams by team away days. From a theoretical perspective, peripheral members have been viewed as potential change agents, having contact with divergent views inside and outside the team, and retaining outsider/insider membership perspectives (Wenger 1998, p. 119). Valuing such members seems essential if teams are to meet the policy challenges. For example, one social worker in a health team thought that team members misunderstood her role, which was exacerbated because there were no role clarifying events that she knew of:

> 'It is clear that there are people in the team who don't understand my role just as I don't understand the roles of everybody else in the team. Because we don't meet, we don't discuss roles, we don't do any group-work, there is no team-building, and there is not a great identity.'

As a result, colleagues either made referrals to her without first consulting family members, or were reluctant to refer to her, since they wrongly saw her as performing a primarily child protection role:

> '. . . There is a misconception at the hospital that social workers are about taking children off their parents, so some doctors are reluctant to make referrals anyway, because they think that they will move in a very heavy-handed way, and that the medical staff's relationship with the families will be totally destroyed.'

The identified need is for inclusion of *all* members in role-clarifying events.

Confidentiality and information sharing

One of the key 'fault lines' along which differences between professions arise is around the issue of information sharing and the value placed upon and the interpretation of confidentiality. Issues of confidentiality and information sharing in multidisciplinary teams present particular challenges, in which social workers are often at the centre.

Information sharing and protocols/confidentiality

Issues surrounding the sharing of information were mentioned by respondents from all of the teams. Social workers often expressed concern about conditions restricting access to health databases. For example, at the youth crime team, the social worker felt that there was a cultural difference between social service and health agency norms:

> 'There's issues around confidentiality sometimes, health records having to be, I suppose all records are supposed to be locked up, but the Health Worker and the Drugs Worker have confidential files which don't go on the system so if you want some information and they're not there to be able to talk through about it, you can't access that information.'
>
> '. . . I'm used to working in an arena where we do share things all the time and so to have somebody come in with a very strict confidentiality policy makes it . . . I found it sometimes more difficult just to work within.'

At the social services-funded team working with young people with emotional and behavioural problems there were concerns, expressed by the team manager, that specific health service databases remained inaccessible, whereas in neighbouring teams which were health funded this might not be the case:

> 'For one example, the Health [team] has a database that is used across the service. We haven't been able to use it yet because we're not part of Health, we're Social Services.'

Conversely, according to the team manager, being funded by social services meant the team had better access to certain social services databases than had other health-service funded and managed teams:

> 'We're part of Social Services, we're obviously part of the Social Services database and that gives us access to information about previous social work involvement and history and that is really useful but the Health teams don't get that.'

Dilemmas of information sharing were confronted in one team meeting which the research team observed. The event illustrates dilemmas being addressed through complementary processes of participation and reification (Wenger 1998). The (social services) manager and (health professional) lead clinicians and other professionals in this team voiced clashing opinions over systems for recording case closures, but then addressed these differences by collaborating to produce new written guidelines for recording and exchanging information.

Relations with external agencies

The multidisciplinary teams in which the social workers find themselves faced particular challenges in how they relate to agencies external to them. This issue helps to define the boundaries between both organizations and professions.

Compatibility of agencies' agendas and procedures

Teams faced dilemmas arising from different agency agendas and procedures. Some problems of clashing priorities work through the system to affect liaison and service delivery at a systemic level. A dilemma of interagency linkage is that even when professionals are members of multiprofessional teams, if they come from a minority agency within the team, their agencies' procedures can be at odds with the majority. The social worker in a health-based team faced a dilemma that social services close cases when specified work is done, whereas the rest of the team would keep working with a child and family until school age:

> 'I think sometimes they perhaps like me to keep cases longer than I do but I can't do that because at the end of the day I'm managed by my team manager in this team and if I've done the work I'm asked to close it, and I close it.'

In one of the health-based teams the occupational therapist and the social worker detailed their concerns about the countervailing pressures affecting discharge of children. On the one side, the hospital system demanded patient throughput, and on the other side, agencies such as housing and social services had their own procedures for prioritizing resource allocation for housing adaptations:

> 'There are different pressures placed on each different team, different priorities and also different waiting list pressures, different schedules of prioritizing . . . It's systems and how they don't marry up and link in that causes delays along the line . . .'

These barriers of agencies having agendas and procedures that do not match the teams' could impact on boundary-working professionals even if they work for the team's dominant agency. For example, the occupational therapist, working alongside the health-based team social worker, had problems with housing not delivering resources for clients' rehabilitation once the child was medically well enough to go home, even though other medical professionals were constrained to press for a discharge date to free up beds:

> '. . . that did actually become a team problem because myself and the Social Worker weren't really having an impact on the problem and things were being promised by the Housing Office that weren't coming to fruition.'
> 'For example, housing did not have a suitable house to adapt for many, many, many months and so we reached stale-mate where the hospital wanted the child to be out, we needed the beds, but this child couldn't be discharged because she couldn't go home, she couldn't go to the toilet, she couldn't have a bath, she couldn't even get into the house, because there was no access, so we had to wait until we got the housing situation resolved, and that took a very long time. So there was conflict there in understanding and appreciating the need, and at the same time we were wasting a very valuable bed-space.'

There was a view that multi-agency teams, such as the youth crime team, which formally represent a wide diversity of interests can collaborate to enhance mutual understandings of different agendas among all agencies concerned with service delivery. Teams need to engage with and understand the structural dynamics of their partner agencies, so they need the internal structure and diverse expertise which supports them in accessing such understandings.

Interagency boundaries and referrals

A key dilemma around interagency boundaries and referrals is that both teams and agencies set referral or inclusion criteria to gatekeep their own boundaries largely because of resource limits and workload concerns as well as in response to core aims. As a result, clients with major needs can fall between the tracks of different services.

Respondents from different teams recurrently mentioned barriers over referrals to social services. At the team working with young people with emotional and behavioural problems, some cases that were not early interventions, and therefore not accepted by the team, were also refused by social services. Social services were described by practitioners as short-staffed and constrained by child protection/children at risk remits and definitions:

> '. . . the one that keeps coming up again and again is that there is an evident gap in the service in cases that we would see to be Social Services cases and Social Services would refer to us, when it is clear that these aren't early interventions. Mental health problems, families in fairly chronic need, and understanding.'
> '. . . families that clearly don't fit within our remit but unfortunately don't fit with other people's remit as well . . .'
> '. . . I think with Social Services it's going to be extremely difficult because my fear is that, I know that they are very very short of qualified social workers and I don't see that improving . . .'

One of the health-based teams faced issues around referrals to social services. For example, a team nursery nurse had referred a family directly to social services because of child protection concerns, and been reprimanded by the team:

> 'I was feeling it was a brick wall type thing so I kept taking it upon myself to make a referral to Social Services because it was getting beyond my remit within the family, working within the family and I got quite a wrist slapping for not actually discussing it with other members of the team before I decided to do that.'

The team social worker meanwhile stressed that team members sometimes over-refer without understanding social services criteria and constraints:

> '. . . they may think it's blatant child protection and we'll talk things through more and I may be able to get them to understand that we need more information before we can pursue things in the way they want to.'

At the special needs nursery also there were concerns, expressed by a nursery nurse, that social services do not respond as quickly as the team might want to child protection concerns:

> '. . . child protection issues, when to get in touch with other professionals, when you think that something's happening and nobody's listening to what you're saying . . . I think what I feel is you tend, if you have a suspicion and you ring up about it, you want them to act on it immediately and sometimes, well they have got to collect all the evidence.'

With the creation of multi-agency teams, then, boundary disputes are not dispensed with. These boundary disputes move and shift and the points of

tension are located at different points than they would be if the multi-agency teams did not exist.

CONCLUSION

In this paper we have drawn from specific elements of our data to reflect on the role of social workers in multi-agency teams. These have been related to the theories provided by Wenger and Engestrom. We now conclude by considering these findings alongside issues relating to the joined-up thinking agenda.

Social work has long been central to joined-up thinking amongst child welfare practice. Arguably social work is *the* joined-up profession – a profession that seeks to liaise, to mediate, and to negotiate between professions and between the professions and the children and their families. In some ways we can see social work as the cement that holds together the service for children and their families, and attempts to ensure that it is connected and forms a coherent whole (Donzelot 1979).

The role of social work in the multi-agency teams is therefore of particular interest. Our research has shown that the social work role in the teams is complex and contested. We have seen that there are actual and potential conflicts about models of understanding, about status and power, about information sharing, and around links with other agencies.

To some extent, therefore, joined-up thinking is more difficult than the initial New Labour agenda suggests. We cannot wish away some of the issues and conflicts that have been suggested by our research. Many of the issues are found in all attempts at co-operation across the professional boundaries – what joined-up teams do is to shift and change the boundaries and the specific nature of the issues. Workers are obliged to address problems but can learn and change from this learning, as one social worker confirmed:

> 'I've retained my identity as a Social Worker but I've gained an awful lot more knowledge about other agencies and about the way they work, how to access different things.'

Whilst conflicts and contested definitions exist and the challenge is a difficult one, we also have a more optimistic agenda for applying joined-up thinking to practice. As Hudson (2002) suggests, it is important that as social scientists we attempt to make a positive contribution to policy agendas. We have indeed found that teams have developed positive ways of working together. They want to make multi-agency teams work and are able to build new ways of working and building their teams even where they face difficulties and conflicts. Professionals highlighted what they had in common, as well as emphasizing that teams thrive on respect for diversity. As one team member put it:

> 'I think we see ourselves as (team) workers, I think we're proud to be (team) workers.'

This pride and a real commitment to joined-up working is shared across the teams we researched and potentially forms the basis for effective joined-up practice.

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