INTRODUCING AN EVIDENCE BASED INTERVENTION: EXPLORING THE EXPERIENCE OF COLLABORATION BETWEEN FRONT-LINE AND SPECIALIST PRACTITIONERS. A THEMATIC ANALYSIS.

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The candidate confirms that the work submitted is his own and that appropriate credit has been given where reference has been made to the work of others.

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ABSTRACT

Introduction: The impact of abuse and neglect on a child, their family and the associated societal costs are well documented. Despite this, there are a limited number of evidence based interventions (EBIs) that are available for families when abuse and neglect is identified and little available guidance for how EBIs should be introduced into existing services. This often results in a gap between the research evidence and clinical practice. Literature focusing on introducing EBIs into existing services identifies collaboration between professionals as a key part of this process. The current research aimed to understand the factors that help and hinder the process of collaboration when an EBI was introduced into an existing service, so that these findings might be applied to other intervention and contexts.

Method: This process of collaboration was explored with front-line and specialist practitioners, when an EBI for child abuse and neglect: Multi-Systemic Therapy for Child Abuse and Neglect (MST-CAN), was introduced into Leeds Children's Social Work Services. Eleven semi-structured interviews were carried out with participants from the social work (n = 6) and MST-CAN team (n = 5). The qualitative data was analysed using thematic analysis.

Results: Three key themes emerged from the analysis that described the process of collaboration: 'adapting the intervention to the local context', 'committing to the intervention' and 'working together to deliver the intervention'. MST-CAN had to be adapted to fit the local context and practitioners had to commit to the intervention before they could begin working together to deliver it. There were ten subthemes from

the analysis that related to factors that helped and hindered collaboration between professionals.

Discussion: The findings of the current research mirrored some of those from previous research and presented new findings in relation to factors that help and hinder collaboration in the context of children's social care. The results are considered in relation to models of collaboration, implications for clinical work and future research.

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

ABBREVIATIONS

All abbreviation are provided in the text the first time that they appear.

AF-CBT:	Alternatives for Families - Cognitive Behaviour Therapy
APS:	Australian Psychological Society
BASW:	British Association of Social Workers
CAMHS:	Child and Adolescent Mental Health Services
CBT:	Cognitive Behaviour Therapy
CYPM:	Crossover Youth Practice Model
DfE:	Department for Education
EBI:	Evidence Based Intervention
ENE:	East North East
GT:	Grounded Theory
IPA:	Interpretive Phenomenological Analysis
MST:	Multi-Systemtic Therapy
MST-CAN:	Multi-Systemtic Therapy for Child Abuse and Neglect
MTFC:	Multidimensional Treatment Foster Care
NSPCC:	National Society for the Prevention of Cruelty to Children
NHS:	National Health Service
PMT:	Parent Management Training - Oregon Model
PMHW:	Primary Mental Health Workers
PTSD:	Post-Traumatic Stress Disorder
RBT:	Reinforcement Based Treatment
RCT:	Randomised Control Trial
STAR:	Sharing a Team Approach to Resource Utilization

TA:	Thematic Analysis
US:	United States (of America)
UK:	United Kingdom
WNW:	West North West

CHAPTER ONE: INTRODUCTION

Child abuse and neglect are highly prevalent in the UK. It is reported that 1 in 5 children have experienced severe maltreatment (Radford et al., 2011) and there are around 50,000 children identified as actively needing protection from abuse (National Society for the Prevention of Cruelty to Children [NSPCC], 2014). Child abuse is strongly predictive of psychopathology (Heim & Nemeroff, 2001), particularly if the abuse is long-term (Simeroff, Seffer, Baldwin & Baldwin, 1993). It has traditionally been the role of children's social care to manage and co-ordinate the care of children at risk of abuse and neglect. Despite our understanding of the associated societal and financial costs of child maltreatment, a limited number of evidence-based interventions (EBI) have been developed to address them (Chaffin & Friedrich, 2004). However, following successful trials in the US, the evidence-based Multi-Systemic Therapy for Child Abuse and Neglect (MST-CAN) has recently been piloted in the UK following a successful Randomised Control Trial (RCT) in America (Swenson, 2010).

Successful introduction of MST-CAN into the UK was not guaranteed as the intervention requires new ways of working between social care and MST-CAN practitioners and therefore effective collaboration. Collaboration is a particularly challenging part of introducing a new intervention and the process of collaboration is poorly understood in the context of children's social care (Theonig, 1998). The purpose of this research is to explore the experience of collaboration between social care and MST-CAN practitioners who are working together to facilitate the implementation of MST-CAN in Leeds Children's Services. It is hoped that through improved understanding that this work will inform practice relating to collaboration,

particularly in the context of children's social care.

Initially, the focus of the literature review is on describing the impact of child abuse and neglect on the victim and in considering the context of children's social care, where the responsibility of managing and responding to child abuse and neglect is typically focused. The emphasis will shift to EBIs that have been developed for child abuse and neglect. In the final parts of the chapter, research that explores a range of factors relevant to introducing an EBI into an existing service will be discussed with a particular emphasis on the process of collaboration.

1.1.Literature review: part one

When the project began development the researcher was aware that there was a new intervention for child abuse and neglect (MST-CAN) that was being introduced into Leeds Children's Social Work Services. The researcher began by reviewing available literature relating to child abuse and neglect, the context of children's social care and what EBIs were available. This involved exploration through the University of Leeds online library using the search function.

1.1.2. Child abuse and neglect

Mistreatment of a young person can include emotional, sexual and physical abuse and neglect (Read, Bentall & Fosse, 2009). Such experiences are known to have a significant impact on mental health and wellbeing in the immediate and long-term. Specifically, physical abuse and neglect place a child at risk of anxiety disorders, depression, aggression and post-traumatic stress disorder (Dube et al., 2001; Turner, Finkelhor & Ormrod, 2006). There are currently 50,000 children identified as needing protection from abuse in the UK and over 62,000 children and young people contacted Child Line to report abuse in 2014 (NSPCC, 2014).

Experience of abuse or neglect in the developmental years predicts both a poorer quality of life for the person who is abused and is also associated with an increased societal cost through a requirement for more health and social care (Wang & Holton, 2007).

Taken together, the individual, financial and societal costs associated with abuse and neglect, confer pressure upon support services to manage and intervene when a child is identified as being at risk. Historically, it has been the role of children's social services professionals to coordinate and collaborate with other professionals (in child and adolescent mental health, education, the police) to support children and their families when a child is identified as at risk of child abuse and neglect. In order to make sense of the past endeavours to meet the need to co-ordinate and collaborate effectively across services, it is important to consider the broader context and discourses surrounding children's social care in the UK.

Recent failings in the system supporting vulnerable children have highlighted how social care professionals often have unmanageably large caseloads and can unfairly carry the responsibility for failings of a multi-professional team (Burke, 2013; Frost, 2014). Typically, when public enquiries take place, the most commonly identified failures and recommendations relate to poor communication between and within services and staff being required to work beyond their capacity (Burke, 2013). In addition to the concerns of front-line staff, there is increasing pressure on staff in senior and leadership positions in children's services, particularly managers and directors to hold responsibility for any failings in the social care system (Purcell, Christian & Frost, 2012).

It is reported that, on average, there is one social worker for every seventeen children that are known to be in need of support (Department for Education, 2014). A

recent report found that practitioners reported the 'current state' of social work was inadequate (British Association of Social Workers, 2012). In response to a survey, it was found that: 88% of social care professionals believed their jobs could be at risk due to cuts in services, 77% of respondents said that their caseloads were unmanageable and 34% stated a desire to leave the profession because of the impact of funding cuts on their ability to practice as a social worker (British Association of Social Workers, 2012). Respondents to the survey made comments relating to dangerously high workloads, and having to manage crisis on a daily basis (British Association of Social Workers, 2012). There are doubts about the extent to which results are generalisable as the size of sample was only a small proportion of over 20,000 social workers in the UK working in Children's Social Services (DfE, 2014). Nonetheless, this feedback emphasises the difficult circumstances in which social workers perceive themselves as required to work.

Detecting and providing evidence for when child abuse is occurring is a challenge for professionals working in children's services. Studies suggest that for every one child identified as at risk of abuse and neglect, another eight are not identified (Harker et al., 2013). Although a significant number of adult survivors of childhood abuse present to services for support, there are also a number of children who experience abuse that do not contact mental health services in later life (Green, 1993). Monitoring those victims of abuse who do not come into contact with services, in order to inform understanding and shape interventions for this group, is very difficult. The aforementioned systemic problems in the health and social care system contribute considerably to the challenge of identifying and intervening to support children who are or have been abused (Akin et al., 2014).

Despite the increased risk to the individual and associated costs of child maltreatment, this situation has remained largely unchanged for a number of years. In part to address this issue, there is a drive to provide better support and improved training for social workers to improve quality of service provision (Holmes, Miscampbell & Robin, 2013). In addition to this, governments in most western social care systems have been attempting to implement novel EBIs to reduce the incidence of child abuse and neglect and to reduce its impact. This type of intervention will enable practitioners to work with the whole family in order to establish new patterns of relating and behaving which can prevent further abuse and neglect. These interventions often require collaboration between specialist practitioners who are trained in the intervention and front-line staff in children's social care. Social workers have a strong set of professional values and need to believe that an intervention is worthwhile if it is going to be introduced successfully (Clark, 2000).

1.1.3. EBI for child abuse and neglect

An EBI can be defined as a type of treatment that has been shown to be effective through outcome measurement, has been presented in published research and increases the chance of improvement, whilst reducing the risk of harm, when applied in the proposed context (Australian Psychological Society, 2011). Usually, the EBI will be considered as effective if it is able to change the target behaviour. In the case of child abuse and neglect, the intervention will attempt to reduce further risk of abuse and neglect by facilitating a change in the behaviour of the parent and child. The effectiveness of the intervention is usually demonstrated through a randomised control trial (RCT), which compares the effectiveness of the intervention to treatment as usual, no treatment or an existing treatment. Given the prevalence and implications

of child abuse and neglect, there are a surprisingly limited number of interventions that are available to target abuse and neglect in families. The reason for this are multi-faceted and may be partly because the concept is relatively new in social care services (Chaffin & Friedrich, 2004).

When an EBI is developed there is a challenge in implementing it into services and ensuring fidelity to the model (Chaffin & Friedrich, 2004). The challenge arises because of the complexity of health and social care services, which means that the intervention will have to be adapted to the context and the need for staff training and resources may make it difficult to facilitate the intervention in the way in which it was intended. This process is complex and as a result, there is a gap between the evidence base and clinical work (Bodenheimer, 1999). Yet, despite this, most clinicians working within services for child abuse and neglect report that their practice is based on evidence-based findings about what works. However, reviews of the services in which these clinicians work have found that this is often not the case (Saunder, Berliner & Hanson, 2004). Because of this trend, approaches to working with a family that are ineffective can often become wide spread, despite evidence that they do not work well (Duggan et al., 2004).

Social care practitioners often work in an evidence *informed* way, however, this is not the same as an EBI as informed practice is often informed by what is popular and fashionable at the time (Berliner, 2002). This is concerning because some interventions that are not evidence-based have been shown to be worse than doing nothing at all (Petrosino, Turpin-Petrosino & Finckenauer, 2000). There are variations in what can be considered as good evidence; one way to determine this, in the context of child abuse and neglect, is to look at the outcomes of the intervention. Good outcomes may include reduced reporting of abuse, improved safety of child, improved

family functioning, stability in the home and improved wellbeing for family members (Chaffin & Friedrich, 2004)

These outcomes have been used to evaluate some EBI for the prevention of further child abuse and neglect. The RCTs for EBI that have been developed in this area are typically evaluating the effectiveness of family-based interventions. Despite the limited amount of interventions, there have been some positive results that have influenced practice in children's social care (Chaffin et al., 2004). For example, Kolko (1996) found positive changes for the child in relation to improved family cohesion, reduced incidence of abuse and improved mental health, when caregivers were receiving concurrent CBT or family therapy, versus outcomes reported in standard community services. The outcomes were measured via self-report and interview and showed that the improvements were sustained at three months and one-year follow-up for both CBT and family therapy. This approach was later developed into a model: Alternatives for Families - Cognitive Behaviour Therapy (AF-CBT; Kolko, 2004). This intensive approach was successful when applied to physically and emotionally abusive parents and their children, who were of school age (Kolko, 2004).

More recently, Swenson et al. (2010) reported positive results for an adaptation of an existing model of family therapy as an intervention for child abuse and neglect in the United States (US). Building on the success of Multi-systemic therapy for young offenders (Butler, Baruch, Hickey & Fonagy, 2011), MST-CAN was developed as an EBI to support children and their families. The key features of MST-CAN are: "intensive (more than three times per week) home-based family intervention, with a focus on engagement; treatment of parental mental and substance misuse problems; 24/7 availability; all social, psychological and medical needs

managed by the MST-CAN team; intensive (daily or weekly) liaison providing continuous information; partnership development around the goals of the intervention and modelling of interventions" (Herbert, Bor, Swenson & Boyle, 2014 p.2).

In a randomised effectiveness trial for MST-CAN, Swenson et al. (2010) found that in comparison to enhanced outpatient treatment, MST-CAN reduced distress, parental behaviours associated with maltreatment, and the amount of youth out of home placements. It was also found that MST-CAN was more effective in improving the levels of naturally occurring social support for parents (Swenson et al., 2010). Families were randomly assigned to each type of treatment and the outcomes were measured at initial assessment and at 2, 4, 10 and 16 months. The study had a high retention rate of 97% across the time points. The methods used in the trial were robust and the findings are likely to be a good representation of the effectiveness of MST-CAN.

Following the successful findings of Swenson et al. (2010), the British government invested in a UK based pilot for MST-CAN. Three sites were initially identified as suitable for the pilot: Greenwich, Cambridge and Leeds. Across all sites, MST-CAN was to be introduced into an existing service and in the case of Leeds, Children's Social Work Services was chosen. Currently there are MST-CAN teams in Leeds and Newcastle, with new teams being developed in Leicester and Nottingham. As discussed above, introducing an EBI intervention into an existing service creates a number of potential challenges for those responsible for introducing the EBI and the practitioners working together to deliver the intervention. Consideration will now be given to what these challenges are and how they can be overcome to facilitate delivery of the intervention.

1.2. Literature review: part two

After exploring the context of child abuse and neglect and children's social care and considering interventions for child abuse and neglect, the researcher wanted to understand what factors might be important when introducing EBIs into children's health and social care and developed a systematic search strategy to explore this further.

To maximise sensitivity, the search strategy (appendix 1) was developed using a range of general terms that were generated through discussion with supervisors and initial reading about implementing EBIs. These were a number of key terms relating to 'health and social care professionals', 'change', 'service development and delivery', 'attitudes and beliefs' and 'communication'. Key terms (i.e. service development) and derivatives (i.e. service change, service implementation) were used to broaden the literature search further. Results that included a combination of all five categories of search terms were included. The search strategy was adjusted to search the following databases: Medline (136 results), Web of Science (215 results), PsycInfo (26 results) and CINAHL (27 results). Initial searches identified 404 papers before de-duplication.

A number of papers were used to inform the general introduction to sections 1.2.1. and 1.2.3., when introducing EBI into existing health and social care services and collaboration between professionals are considered broadly. The papers that were included in the qualitative synthesis related introduction of EBI in the context of psychosocial interventions for child health and social care are discussed in parts 1.2.2 and 1.2.4, where the introduction of EBIs in children's health and social care and collaboration in children's health and social care are discussed. The Prisma flow chart

(2009) contains the results of the literature review (appendix 1). Only twelve papers were included in the qualitative synthesis, which suggests that professional experiences of the introduction of EBI and professional collaboration in child health and social care are areas of limited research.

1.2.1. Introducing EBIs into existing services

Over the past twenty years, there has been increasing pressure on health and social care services to provide high quality care, that is evidence-based and can faciliate cost saving. As a result, the concept of EBI has become part of the common discourse in health and social care (Wilson, 2012). Introducing EBI into routine clinical practice is a demanding and complex task and there is often a gap between the latest research evidence and what happens in clinical practice (Bodenheimer, 1999). As a result, service users do not always have access to the interventions that are supported by the best scientific evidence (Soydan, 2009). There is resistence from some who argue that clinical practice is too complex and subjective to be evaluated using clinical science (Clemens, 2002).

A number of researchers have attempted to establish which factors prevent or facilitate the implementation of an EBI. However, despite the aforementioned complexity of children's social care services, there is limited guidance available for how to introduce an EBI into this context. Research in comparable populations can be used to identify factors which may also be important when introducing an EBI into children's social care. Consideration will now be given to literature that focuses on factors that are important when introducing EBI in health care settings and in children's social care.

Individual perceptions of the EBI are an essential aspect of the implementation process. Sackett, et al. (1996) suggested that medical clinicians often feel that clinical research does not translate well to what is best for the patient and does not always match their clinical experience. This mismatch is a barrier to the facilitation of an EBI in health settings. Other authors have suggested that positive perceptions of the EBI are crucial if it is to be implemented. Grol and Grimshaw (2003), in providing an overview of the key issues regarding implementing EBI, describe how the individual's perceptions about the usefulness of the intervention and their level of motivation towards using it were a crucial part of the implementation process. From a practical perspective, Ogundele (2011) suggested that barriers to implementation can include poor availability of guidance for an EBI. These barriers can be overcome if the practitioner's negative perception of the intervention is altered. Kitson, Harvey & McCormack (1998) found that evidence is more likely to be valued by practitioners if the EBI is supported by good quality research and clinical findings. In addition to this, the guidelines for EBI are most useful if they present clear and practical recommendations for improvements to existing services (Ogundele, 2011).

When a professional is interested in applying EBIs to their work it could be seen as a potentially overwhelming task; it is estimated that around 3000 new research papers including 50 Randomised Control Trials (RCTs) are published each day (Coppus et al., 2007; Sackett et al., 1996). Although only a small amount of this research is relevant to the individual practitioner, remaining up to date with current EBI is challenging. The context and environment of the service are important in determining if the implementation of the EBI will be successful. If a professional is wanting to implement an EBI or be part of a team working with an EBI, it is crucial that they are working in an environment that is conducive to progressive change (Grol

& Grimshaw, 2003). As a result, an essential part of successfully introducing an intervention is related to developing a professional setting that enables practitioners to produce the best quality of care (Lanie et al., 2003).

In the context of the professional setting, implementation of an EBI is best facilitated by suitable workloads, opportunity for feedback and effective leadership (Kitson, Harvey & McCormack, 1998; Grol and Grimshaw, 2003). In particular, leaders and other key facilitators should have an approach that ensures respect, empathy, flexibility and consistency (Kitson, Harvey & McCormack, 1998). Ogundele (2011) suggested that improving implementation of guidelines of EBIs should be an integrated, multi-displinary effort if it is to be effective and sustainable. Specifically, this effort should include: continuing education, lectures, greater availability of patient information sheets, distance learning forums and specific information about implementation of EBIs in clinical practice. Grol and Grimshaw (2003) suggested that educational strategies, audit and feedback, mass media campaigns, financial interventions and multi-professional collaboration could also be used to facilitate successful implementation of an EBI.

Much of the above research is a commentary representing the author's opinions and is not necessarily evidence for the validity of their views. The evidence considered is often in other contexts and extrapolated to other contexts where an EBI may be introduced. For example, Grol and Grimshaw (2003) focus on the research evidence about the implementation of hand hygiene into medical settings and extrapolate the messages from implementing that intervention to considering how other EBIs can be introduced. Kitson, Harvey & McCormack (1998) proposed a conceptual framework that is based on available research evidence but do not present evidence that the framework was successfully implemented. Ogundele (2011)

reviewed the available research around introducing an EBI but a lack of data made it difficult to assess the effectiveness of the guidelines that were developed. However, the reviews presented are based on extensive clinical experience and available evidence from other research and is valuable in considering the concepts related to introducing and EBI.

In summary, despite the drive for EBI, implementation is complex and demanding, which often leads to gaps between the research and provision of clinical services and there are a number of barriers and facilitators to the process. It is also important to consider the individual's perception towards the EBI. Unsurprisingly, a positive perception of the EBI is important in successful implementation and can be facilitated by good quality, accessible research and clear guidelines for staff. The service context is important as it is easier to implement an EBI in a service that is amenable to change and supportive of the best quality of care. Such a setting has suitable working routines and workloads, opportunity for feedback and effective leadership. A multi-disciplinary approach is required to facilitate implementation, including education, availability of information, media campaigns, financial support and multi-professional collaboration.

The above research was conducted in the context of introducing an EBI into healthcare. The information presented is potentially biased as the majority of the information is a summary of the author's interpretation of how evidence-based practice can be facilitated in the context in which they work. Despite this limitation, these interpretations can be helpful in considering what factors may facilitate the introduction of an EBI. The context of healthcare shares some similarities with children's social care because professionals working in both areas have to make clinical decisions that will impact on a service user's well-being. However, healthcare

is different to children's social care because EBIs are a more routine aspect of care in medical settings; in children's social care services, it may be that professionals are unaware of any EBIs. In addition to this, the training differs between professional groups; in medicine, doctors receive a number of years of training during which they become familiar with the concept of EBI. These factors would make it difficult to generalise the findings from the above literature to children's social care.

1.2.2. Introducing EBIs into children's health and social care

The paucity of research focusing on the introduction of EBIs into social care organisations may be partially explained by the limited number of EBIs that are available for use in this area (McCrae et al., 2014). It can also be difficult to complete research due to the preventative influence of bureaucracy in the child social care system i.e. numerous regulations, strict timelines and multiple stakeholders (Akin et al., 2014). In addition, communication between parts of the child social care system can be difficult as front-line staff may prioritise spending time with families or attending court hearings rather than making themselves available for innovation and research activities (McCrae et al., 2014). Despite these challenges, the following research, from the qualitative synthesis of the literature review, has focused on the process of introducing changes in service provision into child health and social care settings**.**

In a well-conducted qualitative study, Macdonald et al. (2004) explored barriers to introducing Primary Mental Health Workers (PMHW) into Child and Adolescent Mental Health Services (CAMHS) in the UK. Through conducting semi-structured interviews with 75 key professional stakeholders, thematic analysis of the data revealed that barriers to introducing the new staff members included problems in

ensuring links to facilitate collaboration between all parts of the service and accommodating specific requirements of the PMHW role (i.e. consultation with less skilled staff) alongside their core clinical responsibilities. In another UK-based study, Tinati et al. (2012) explored the barriers to introducing a training program for social services professionals, which focused upon Healthy Conversation Skills. One hundred and ten professionals (primarily support workers, play workers and nurses) attended an evaluation workshop following their training. Similarly, they experienced difficulty in establishing collaborative relationships and finding time to have 'healthy conversations' as well as struggling to create opportunities to do so. The practitioners attributed this to the high level of demand in their roles, which made it difficult to practice in this way.

Both McDonald et al. (2004) and Tinati et al. (2012) explored the barriers to introducing service change. In contrast, Akin et al. (2014) explored the barriers *and* facilitators following the introduction of an EBI for child social care in the US: Parent Management Training, Oregon Model (PMTO; Forgatch & Patterson, 2010). From the 28 professionals that participated in the study, their thematic analysis revealed that low confidence, confusion and discomfort were experienced in the integration stage of introduction and found it was essential to create a safe learning and working environment to counteract this. Mutual sharing of information between stakeholders, effective supervision and strong peer support were also critical in introducing the EBI (Akin et al., 2014). In another U.S. study focusing on introducing an EBI, McCrae et al. (2014) evaluated the professional experience of introducing a large-scale, public child welfare program in the U.S. They conducted interviews and focus groups with 52 professionals. Using the framework of Rogers' (1995) 'Diffusions of Innovation Theory', the researchers found high levels of 'buy-in' across the organisation. In

particular, if supervisors were knowledgeable about the intervention, the professionals were more open to adopting new ways of working. Supervisors were a crucial part of successful introduction of the child welfare program.

A key limitation across the studies described above was a problem with the sample selection. Macdonald et al. (2004) had a partial sample (only one social worker was represented) and interviewees were selected based on recommendations from other professionals, which may have led to biased responses. Tinati et al. (2012) used self-evaluation, which is less objective and does not provide the detail of a qualitative interview. McCrae et al. (2014) and Akin et al. (2014) had samples that lacked diversity, consisting of practitioners who were mostly white females who had attended a higher education institute. Such a homogenous sample will have limited the quality of information that they would be able to obtain, as there was a lack of variety in professional background. Also, some researchers adopted a problem-focused approach and only explored the barriers involved in inhibiting success of the EBI. The research conducted in the U.S. social care system operates in a different health and social care context, therefore limiting the comparability to UK contexts because of funding, staffing and service organisation differences.

Notwithstanding the limitations identified, the research that has been conducted proposes that successful introduction of EBI involves recognising and nurturing the influence that close colleagues have on the professional's perception and understanding of the intervention as this influences how likely they are to support it. Macdonald et al. (2004) highlighted the difficulty in balancing demands of any new role when introducing EBI. Levels of 'buy in' from participants were higher if senior staff were knowledgeable about the intervention and could inform and facilitate attitude changes in other staff, thus increasing their enthusiasm for the EBI (McCrae

et al., 2014). It is also important that people implementing the services are able to foster an environment, which improves staff confidence in the EBI (Akin et al., 2014). The components that the research has identified as contributing to successful introduction of an EBI can be thought of in terms of individual factors i.e. staff buy in, balancing demands, managing of workload and experiencing a safe environment for learning.

The context for these individual factors is set by broader systemic factors, such as: planning the EBI; staff training; collaboration between professionals; evaluating and adapting to feedback. From these factors, research has focused most specifically on collaboration. Collaboration is not a new challenge in child social care, as professionals have been encouraged to work in partnership alongside other health and social care professionals for a number of years (Bronstein, 2000). However, facilitating collaboration is perhaps a particularly challenging part of introducing an EBI due to differences between professional groups. These differences can include training backgrounds, professional values, ways of working with professional groups, and aims of the intervention.

1.2.3 Collaboration between professionals

The needs of service users frequently co-occur e.g. child abuse and neglect will often occur alongside mental health problems, domestic violence and substance misuse (Derr & Taylor, 1999; Bromfield et al., 2010). These co-occurring needs have implications for how different parts of the health and social care system work together. As a result, collaboration between practitioners is the central problem in any collective undertaking (Theonig, 1998). In the UK, social welfare policy has advocated for collaboration within and between services since the New Labour

Government in 1997 (Dowling, Powell & Gledinning, 2004) and it remains a key compenent of how the National Health Service operates (NHS England, 2015).

Over the last 20 years, worldwide, there have been efforts to design and introduce collaborative clinical practice in a bid to improve service delivery and standards of care (e.g. Bjørke & Haavie, 2006). Accreditation bodies in health and social care have created policies and issued advice relating to increased collaboration (National Association of Social Workers, 2013; The Accreditation Council for Graduate Medical Education, 2015). However, less attention is paid to the potential drawbacks to this enthusiasm for collaborative practice, namely that a lack of guidance and planning can lead to confusion and unsuccessful collaboration (Miller & Ahmad, 2000; Anning et al., 2006). In order to avoid these potential pitfalls and understand how to ensure successful collaboration, it is useful to develop a robust understanding of the concept.

The academic literature for collaboration has been described as "definitional chaos" (Ling, 2000, p.82). This is partly because terms such as 'co-operation', 'joint working' and 'partnership' are used interchangebly with 'collaboration' (Powell & Glendinning, 2002). Brandon (1996, p.323) defines collaboration as "bringing together individual providers and practitioners with a common sense of mission and the collective resources to achieve it". Asthana (2002) suggested that collaboration often involves mutual sharing of knowledge, principles and understanding. Gray (1989, p.235) reflected on how this process enables the practitioner or service provider to "explore…their differences" and "search for solutions" to achieve what they could not have done with one group alone. Collaboration can involve sharing of ideas and information, collective action towards a shared goal in the spirit of "harmony and trust" (D'Amour et al., 2005 pp. 116). In the context of health and

social care, partnerships between teams are important in collaboration, as is interdependency, and staff empowerment (Sullivan, 1998; Evans, 1994; Cowan & Tivet, 1994). Collaboration is an evolving process of transformation that is both interactive and dynamic in nature (Sullivan, 1998; Stichler, 1995).

1.2.4. Collaboration in children's health and social care

The following research, from the qualitiative synthesis of the literature review, has focused on professional experiences of collaboration in child health and social care. Building on previous education programs that produced favourable results in other areas of research (Edinburg et al., 1978; Mazur et al., 1979), Coleman et al. (2008) evaluated a new educational approach as part of the US child social care system: Sharing a Team Approach to Resource Utilization (STAR). The participants (n = 159) completed surveys and were rated by STAR team leaders; the researchers found that the STAR program led to a statistically significant improvement in the participants' attitudes towards inter-professional collaboration. They also found evidence of improved team working skills measured before and after attendance on this program in comparison to non-team learners. However, there was no evidence that these team working skills translated into professional practice. Clark (2011) used survey items in combination with focus groups to explore the attitudes of 21 professionals towards inter-professional education and inter-professional practice in Norway. The results, obtained via focus group and online survey, revealed that participants reported many positive outcomes from team working, which included learning about the patient needs, their own needs, those of the team and developing awareness of how to address them. Shared decision-making and agreeing joint accountability also supported collaboration (Clark, 2011).

Anderson-Butcher, Lawson and Barkdull (2002) evaluated a service development across four US states that required professionals to collaborate. They obtained survey results from 48 design team members and completed 22 qualitative interviews. The researchers found that the strengthening of face-to-face and digital communication networks led to improved service delivery, promoting better relationships between professionals during the initial stages of collaboration and ensuring this was maintained throughout the process of working together. This was taken as evidence that the professionals had developed the competencies to work together, although there was no objective evidence that this was the case. In a similar size Australian study, van der Ham et al. (2013) evaluated a three-part collaboration consisting of child mental health, adult mental health and community child services. This collaborative effort was implemented to address a gap in service delivery for mothers with mental health problems and their children. There was no specific guidance or support for the process of collaboration and the twelve professionals who provided feedback reported that through co-facilitating the program, there was a strengthening of professional networks, a greater appreciation for each other's roles and the development of shared knowledge, which they could use within their service. However, there was no evidence of what facilitated the process of inter-professional collaboration to which the positive outcomes of the intervention were attributed.

Haight et al. (2014) explored professional experiences of implementing the Crossover Youth Practice Model (CYPM) in five counties of one American state. They focused on collaboration within the process of multi-system development, by interviewing 84 professionals involved in the introduction of the CYPM. When reporting on their experiences of the collaboration, professionals reported a positive shift in how they think about youth and their families and how they view other

professionals. Qualitative analysis revealed that collaboration was moderated by existing relationships between professionals, availability of resources, leadership of senior professionals and involvement of front-line workers.

The concept of professional networks and their implication for collaboration was further investigated in another US study, in which Palinkas et al. (2011) explored how social networks affect the implementation of Multidimensional Treatment Foster Care (MTFC; Chamberlain, Leve & Degarmo, 2007). MTFC aims to reduce rates of residential care, arrest, substance misuse and mental health problems in children and adolescents. The researchers conducted 38 interviews with administrators of the program found that leaders developed and maintained professional social networks through which they could share information. It was reported that effective collaboration was dependent on key facilitators of the collaborative process, such as directors or administrators who have knowledge and experience beyond only one part of the service. Poor collaboration was thought to have resulted from a lack of funding, difference in the priorities of professional groups, differing organisational strategies and strained relationships that emerged as a consequence of these circumstances.

In the single research paper found that related to the introduction of a specific intervention for child abuse and neglect, Herbert et al. (2014) investigated the outcome of collaboration between an MST-CAN team and a social services team in Australia. They conducted five qualitative interviews with the social care team members working alongside MST-CAN to explore how the outcomes of the collaboration. There were a number of reported benefits to the collaboration, such as increased availability of family support, good communication with the MST-CAN team members and an experience of a partnership ethos. There was also a reported change in perceptions of the social care team and a change in the way that they

approach treatment as they learnt from the MST-CAN team. These positive experiences were attributed to the core features of the MST-CAN model, which includes intensive intervention, liaison with other team members, providing information and partnership development.

There are a number of limitations to the research focusing on collaboration. Coleman et al. (2008) used a self-rated measure of team working which lacks objectivity. The lack of comparison group made it difficult to establish if the findings result from the STAR program or other factors i.e. shared learning experience. Similarly, Clark (2011) may have limited accuracy as the studies were in English whilst the mother tongue of participants was Norwegian. Anderson-Butcher, Lawson and Barkdull (2002) asked leading questions to participants, such as 'what do you believe have been the major accomplishments of the design team', which may have impacted on the responses given. In the Haight et al. (2014) study, some participants were involved in organising the implementation and would have a vested interest in its success.

Van der Ham et al. (2013) and Herbert et al. (2014) had low participant numbers (twelve and five, respectively), which may only represent a limited range of experience. Anderson-Butcher, Lawson and Barkdull (2002) and Van der Ham et al (2013) did not explore the professionals experience in great detail as they did not ask open-ended questions, this may limit the quality of information they gained. Palinkas et al. (2011) conducted their investigation during the initial stages of the EBI implementation with a small number of counties in the US; their experience may differ from those in later stages. Most of the studies only explored the view of one group of professionals, or some groups were under-represented. For example, Herbert et al. (2014) only considered the outcome of collaboration from the perspective of one

half of the collaborative relationship as they did not ask for the experience of MST-CAN practitioners.

All of the studies considered failed to establish if any of the reported benefits of collaboration were present before the introduction of the EBI and Herbert et al (2014) found that the team reported values similar to that of the MST-CAN approach before the collaboration. The MST-CAN team member conducted the interviews, which is likely to have impacted on the quality of responsive and may have produced more desirable responses from the respondents. A number of studies focus on the outcome rather than the process of collaboration. Focusing on the outcome helps to determine if the collaboration was successful or not but does not help the understanding of what facilitates successful collaboration. For example, Herbert et al. (2014) van der Ham et al (2013) spoke about the positive benefits of inter-professional collaboration but this does not enable replication of the factors that facilitated this success.

1.2.5. Summary

Collaboration is an important component of what determines successful implementation of an EBI. However, there is limited understanding of what facilitates successful inter-professional collaboration in children's social care. However, from the research that is available there are a number of relevant themes: collaborative training, strengthening communication networks, leadership, shared decision-making and changes in attitudes and behaviors. These findings were used to develop the interview topic guide for the present study (appendix 2). A summary of these relevant themes is presented below.

The research that has been completed is within the last ten years and is therefore relatively up to date. The majority of the research has been implemented in

the US, which has a different organisational and professional context to the UK system. The current impact of austerity measures on health and social care in the UK and increased demands on the services, mean that it is important to understand what facilitates the introduction of EBI and collaboration in the context of UK children's social care. In some parts of the UK, there are even greater demands on child protection services because of recent failings in social care systems. Taken together, the recent negative events and political context mean that the bureaucracy, regulations, strict timelines and multiple stakeholders that are present in most Westernised health systems are intensified (Akin et al., 2014). A number of key findings emerge from the literature on facilitating inter-professional collaboration when introducing a new EBI in children's health and social care.

Collaborative training. Coleman et al. (2008) found that training together (i.e. with another professional group) improved attitudes towards inter-professional collaboration and led to better team working skills. This was emphasised by Clark (2011) who found that positive rewards from team working, shared decision-making and accountability were also important in supporting collaboration. This finding is further supported by previous research focusing on collaboration in other health care teams (San Martin-Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005). To ensure that professionals have the skills to collaborate, leaders must ensure that they help to improve communication, team development and to be able to negotiate and resolve conflict as required (Fine, 1998).

Communication networks. As discussed in part 1.2., when public enquiries take place into failings in the child protection system, the common failures relate to communication between and within services and staff working beyond their capacity. Anderson-Butcher, Lawson and Barkdull (2002) found that good communication led

to improved service delivery and better relationships during the initial stages of collaboration which remained throughout the collaborative process. This builds on previous research, which has shown that collaboration in the early stages of the partnership is crucial for continued success (Wolff & Gillian, 1991). Van der Ham et al (2013) found that communication and collaboration were connected in a reciprocal way; as well as strong existing communication networks facilitating collaboration, the process of collaboration strengthened professional communication networks. Through collaboration, different professional groups developed a greater appreciation for each other's roles and shared knowledge, which they could use within their service. They also found that the initial stages of implementation were crucial, as was a stable environment to learn.

Key facilitators. Palinkas et al. (2011) effective collaboration requires individuals with knowledge and experience beyond one part of the service. It has previously been shown that introduction of an EBI into a health setting is more likely to be successful if the professionals believe the intervention will be necesssary and beneficial (Bouckenooghe, 2010). This belief can in the intervention can be faciliated by improving motivation to change (Weiner, Amick & Lee, 2008) and providing consistent leadership (Frambach & Schillewaert, 2002). These factors can be successfully introduced and sustained by making people who are the key facilitators of collaboration available following introduction of the EBI. This relates to Rogers' (1995) Diffusion of Innovation theory which proposed that successful introduction of EBI involves recognising and nurturing the influence that our closest colleagues have on our perceptions and understanding. With this, those co-ordinating the service change can understand and indirectly influence an individual's willingness and motivation to change (Weiner et al., 2008). The influence of these 'trusted'

professionals has been shown to aid successful introduction of EBI and collaboration (Valente, 2006; Valente, Chou & Pentz, 2007).

Change in attitudes and behaviours. Haight et al. (2014) found that professionals reported a positive shift in how they think about youth and their families and how they view other professionals following collaboration. The extent of the impact of the collaboration was moderated by numerous factors, for example, the existing relationships between professionals. Freeth et al (2002) suggested that in addition to this, professionals should have understanding of the roles of other professional groups and opportunity to practice collaboration. This is supported by previous literature reviews which have suggested that those facilitating collaboration should encourage team members to establish their professional identity by considering what contributions they can make and by establishing a common language with other professionals to facilitate better communication (Davoli, 2004).

The present study aims to contribute to the literature on professional collaboration in children's social care, when introducing a new EBI, through capturing the perspectives of front-line and specialist practitioners working with MST-CAN in Leeds Social Services through the introduction of the EBI. The research focusing on collaboration between professionals in child social care converged on a number of key findings that were used to guide the construction of the semi-structured interview 'topic guide' (appendix 2). The present study will capture the experience of collaboration from both professional groups. This collaboration is unique as it combines a setting that is under researched (Children's Social Care in the UK) and explores specifically the collaborative relationship between specialist MST-CAN practitioners and the social work practitioners working in the Children's Social Care team. Herbert et al. (2014) conducted a similar study in Australia but had a very

limited number of participants, focused on the outcomes rather than process of collaboration and only the social care team's perspective of the collaboration was considered. This research will explore the experience of inter-professional collaboration from the perspective of both MST-CAN and social work practitioners. Through this it may be possible to better understand how collaboration was experienced by these professionals and provide recommendations for facilitating future collaboration when introducing an EBI.

1.3. Models of collaboration

The researcher came across theoretical models of inter-professional collaboration in the literature review, which are of potential relevance. They were not presented in the literature review because the models were developed in contexts outside of children's social care services and because the method of data collection was not theory driven. The models of collaboration will, however, be discussed in relation to the findings of this research in part 4.5. of chapter four.

1.4. Research aim and question

Research aim: *to explore the process of inter-professional collaboration between social work and MST-CAN practitioners when an evidence-based intervention for child abuse and neglect is introduced.*

Research question: *what factors help or hinder the process of inter-professional collaboration between social work and MST-CAN practitioners when a specialist intervention is introduced?*

CHAPTER TWO: METHOD

The introduction of the MST-CAN intervention in Leeds Children's Services provided a unique and challenging opportunity for social work and MST-CAN practitioners to work together in order to provide an intervention for children who are at risk of abuse and neglect, and their families. In order to explore the process of inter-professional collaboration from the perspective of each professional group, a qualitative, semi-structured interview approach was chosen to allow a detailed exploration of their experiences working together to deliver the intervention.

2.1. Service context

Leeds is a city in West Yorkshire, England, with a population of over 766,000 people. The metropolitan borough of Leeds also includes ten towns outside of the city centre. This entire area is covered by Leeds Social Services, which is divided into Adult Social Care and Children's Social Work Services. The Children's Social Work Service is divided into three teams, which are defined by their location: South team, West North West (WNW) team and East North East (ENE) team. There are ten local children's social work teams in each of these areas and four looked after children teams in each area.

Children's Social Work Services implemented MST Standard in 2008 and, following successful outcomes, MST-CAN was implemented at the end of 2013. Leeds Children's Social Work Services was one of three UK pilot sites exploring the feasibility of implementing MST-CAN in the UK, since 2013. The other two pilot sites in Greenwich, London and Cambridge, have discontinued the delivery of MST-CAN. Since then, MST-CAN has been implemented in Newcastle and there are plans

to implement MST-CAN in Leicester and Nottingham. The MST-CAN service in Leeds is the longest running implementation of MST-CAN in the UK.

Social work professionals in Leeds are able to refer a family to MST-CAN if a young person is at risk of abuse and/or neglect and they believe that their family would benefit from the MST-CAN intervention. The referral to MST-CAN is made using a screening form which requires basic, descriptive information about the child and family. Once a referral to MST-CAN is submitted, it is reviewed by a panel that decides which families are most suitable for the service. The panel consists of the MST-CAN service manager and three social care service delivery managers from the South, ENE and WNW Children's Social Work Services teams in Leeds. For a family to be considered suitable for the intervention, the referral must provide evidence of the following criteria: a recent incident of child abuse or neglect (within the previous six months); an escalation in the required level of support for the family, with a child protection plan put in place; and specific problems or behaviours that can have been identified.

The availability of the MST-CAN intervention is limited and the team are only able to accept a maximum of nine referrals for each six to nine-month intervention cycle as each MST-CAN practitioner (n = 3) can work with three families at any one time. The number of referrals received has so far exceeded this amount, which means that some referrals have not been able to be accepted. The decision to choose a family when multiple referrals meet the basic criteria is based on additional criteria and the decision is made in collaboration between the referral panel members. The additional criteria include, where each therapist is based (each of the three MST-CAN therapists are allocated to one locality) and deciding which out of the families referred would potentially benefit most from the intervention.

Once accepted, the referral is reviewed with the social worker and the MST-CAN therapist meets with the family, who can then decide if they want to 'opt-in' to working with the intervention. The MST-CAN manager emails the social work practitioners one month before the referral forum and if a referral is submitted at this point, it typically takes around eight weeks before the MST-CAN intervention can begin with the family. At the beginning and during the intervention phase, the MST-CAN practitioner is in constant contact with the social work professional. The MST-CAN and social work practitioners negotiate their role in the intervention, usually the social worker remains the statutory lead, which means that the child protection concerns are responded to by them. The MST-CAN practitioner becomes the clinical lead, which means that the social work practitioners identify the key problems for a family and the MST-CAN practitioners carry out the clinical intervention to address these problems.

The MST-CAN practitioners provide an intensive intervention and are available for the family to contact both during and outside of office hours. The MST-CAN intervention includes developing a safety plan and 'fit' for the key problems. The 'fit' forms part of the initial assessment and attempts to establish where multi-systemic aspects of a problem fit together by identifying key 'drivers' for each problem. The 'fit' is usually developed for three key problems and are used as a working hypothesis, which guides the focus of the intervention. MST-CAN practitioners are also able to support family members with drug and alcohol problems using Reinforcement Based Treatment (RBT). MST-CAN practitioners are trained in some techniques from Cognitive Behaviour Therapy (CBT) and although they are not CBT therapists, they are able to provide support to family members using these techniques. Throughout the intervention, the MST-CAN practitioners will attend

meetings with the social work practitioners and they also have 'investment check' meetings that take place every eight weeks in order to review the progress of their work together.

2.2. Sample selection

The participants were identified, recruited and the interviews were arranged through the following four-step process.

Step one: Identifying potential participants. MST-CAN managers and managers in the Leeds Children's Social Work Services were contacted by the researcher and asked to identify suitable participants. The MST-CAN administrator sent a brief email inviting all social work practitioners that had made a referral for the MST-CAN intervention to take part in the research. The email was also sent to all MST-CAN practitioners, inviting them to take part in the research.

Step two: Confirming eligibility. The practitioners who were interested in taking part responded to the initial email. Suitable participants were then selected based on information about their role and experience with MST-CAN, which was provided by the MST-CAN administrator. The selection was based on the following criteria: a mix of MST-CAN and social care practitioners; practitioners who had worked with at least one family using the MST-CAN intervention; and where possible, those with a diverse range of experiences i.e. newly qualified and experienced practitioners. In an attempt to avoid bias in the sample, all practitioners who had completed one-cycle of MST-CAN either as social workers or MST-CAN practitioners were invited to participate, regardless of the outcome of the intervention or the perceived quality of the collaboration between the professionals.

Step three: purposive sampling. Once the researcher had identified which participants would be suitable to take part in the research, an email with details of the research project (appendix 3) was sent to each of the potential participants (n = 15), outlining the purpose on the research and directing their attention to the participant information sheet (appendix 4), which was attached to the email. The potential participants were given a link to an online scheduling tool (Doodle poll), where they could choose a potential interview day and time to take part. The lead researcher also advised the potential participants to get in contact if they had any questions or concerns about the research.

Step four: confirming participation. Completing the online scheduling tool was considered as confirmation that the participant was willing to take part in the research. When the participants agreed to take part in the research, they were contacted via email to confirm their location on the scheduled interview day. If at this point the participant said that they did not want to take part, they were thanked for the time that they have given until that point. If they agreed to take part, the time and location of the interview were confirmed. One participant who agreed to take in part in the research was unable to do so because of a change in their schedule immediately before the interview and difficult arranging another interview time. All other participants that were identified as suitable candidates agreed to take part and completed the semi-structured interview. The interviews were completed during September and October 2015.

2.2.1. Participants

The participants (n = 11) consisted mostly of females (n = 10), with only one man taking part. The participants were a mix of social care professionals (n = 6) and MST-CAN practitioners (n = 5). The social care professionals consisted of participants working as social workers (n = 4) and those working as advanced social work practitioners, who were social workers in a more senior position within their team (n = 2). The MST-CAN practitioners consisted of participants who worked as MST-CAN therapists (n = 2), MST Standard therapist (n = 1) an MST-CAN supervisor (n = 1*)* and an MST program manager (n = 1). The MST Standard therapist had previously worked as an MST-CAN clinical support worker. This role involves providing support to all of the MST-CAN therapists i.e. working with the MST-CAN therapist to deliver the intervention. The MST Standard therapist was able to talk about her experiences when working as an MST-CAN clinical support worker, which was an experience more relevant to the aims of the interview. The MST program manager was involved in the introduction of MST-CAN into Leeds Children's Services. They were able to talk about their experience of working alongside the MST-CAN and social work practitioners during and following the introduction of MST-CAN into Leeds Children's Services.

MST-CAN practitioners are trained to facilitate this specialist intervention, having completed the minimum of a four-day introductory training session that includes the following areas of learning: understanding child abuse and neglect; understanding the treatment principles of MST-CAN; developing intervention skills to work with a family i.e. functional analysis, working with Post Traumatic Stress Disorder (PTSD), CBT for anger, reinforcement program for substance misuse (MST Services, 2016). The MST-CAN practitioners had previous experience of working in

other roles in health and social care before undertaking their role with MST-CAN (i.e. nursing and family therapy). Some MST-CAN practitioners had previously worked as social work practitioners before undertaking their current role.

Social work practitioners have completed the basic level of training in social work (honors or post-graduate degree in social work) and some have completed further training and are advanced social work practitioners. This further training changes the emphasis of their role. For example, the advanced practitioners are in a position of leadership within their profession and are able to inform and shape policies and practice in social care (Institute of Psychiatry, 2016)

2.3. Research setting

The interviews were conducted in a variety of locations in which the Leeds Children's Social Work teams are based; primarily in Osmonthorpe, Pudsey, Headingley and Leeds City Centre. These locations were agreed through discussion between the lead researcher and the participants; the chosen locations were generally where the participants was based for their work on the day of the interview. When possible, the participants and lead researcher ensured that there was a private room in which the interview could be conducted to ensure confidentiality and enable clarity of the audio recordings. This was able to be facilitated for all interviews apart from one that was in an open-doored booth in a large open-plan space. However, the participant reported that they felt able to share their experiences of working with MST-CAN openly as they had recently moved to a new role within Leeds Children's Social Work Services. In addition, the office space was not very busy during the interview so it was unlikely that the interview would have been overheard. When the lead researcher listened to recordings to transcribe one interview and to quality check those that were

transcribed externally, this was done using headphones. This ensured that no people nearby were able to listen to the audio recording of the interviews.

2.4. Interview procedure

Semi-structured interviews were conducted using the interview topic guide (appendix 2) that was developed from the literature review described in Chapter One. The interview questions were based on key themes that emerged through other research that has explored the process of collaboration between professional groups in the context of children's health and social care. These themes were used to provide a basic structure for the topic guide whilst ensuring that the questions asked remained open in order to facilitate a broad discussion of the process of collaboration between the social work and MST-CAN practitioners. The interview topic guide (appendix 2) contained questions that related to five key areas:

1) The participant's perspective of what factors that helped and hindered the introduction of MST-CAN into Leeds Children's Social Work Services
2) The participants experience of working with Leeds Children's Social Work Services/MST-CAN
3) The participant's experience of communication with Leeds Children's Social Work Services/MST-CAN
4) The participant's experience of leadership in relation to who introduced MST-CAN into Leeds Children's Social Work Services
5) How the participant's perceptions and behaviours have changed whilst working with Leeds Children's Social Work Services/MST-CAN

The questions were adjusted depending on the participants professional group e.g. social work practitioners were asked about their experiences of working alongside

MST-CAN practitioners and the MST-CAN practitioners were asked about their experience of working alongside social work. However, some participants described their experience of working with their own professional group e.g. social work practitioners spoke about their experiences of working with other social work practitioners when MST-CAN was being introduced.

The topic guide was refined following the first three interviews. Subsequently, some questions were altered, resulting in the second version of the topic guide (appendix 2). These changes were made in order to improve the flow of the questioning, to re-order questions so that they were asked in a more logical order, to elaborate on some questions that were too vague and to ensure that the wording of the questions meant that they were relevant for both the social care professionals and the MST-CAN practitioners. The questions did not change after the third interview. The content of the questions asked remained thematically consistent with the first version of the topic guide and in-line with the findings of the literature review and therefore data from all 11 interviews are included in the analysis.

At the beginning of each interview the participants were given a paper copy of the participant information sheet (appendix 4). Once they had read the sheet they were asked if they had any questions about the information presented, or about the research more generally. Following this, participants were given the consent form (appendix 5) to read and asked to sign to confirm they were still willing to take part in the research. The interviews were digitally recorded using a dictaphone. Interviews lasted between 31 and 78 minutes. Once the interview was completed, the participant was given further opportunity to ask questions about the context of the research. They were informed that they would be contacted once the thesis was completed and presented with a summary of the key findings of the research.

The audio recordings were uploaded and stored on a secure University of Leeds server. One interview was transcribed by the lead researcher to enable a greater level of familiarity with the data. Ten of the data files were anonymised and uploaded to the transcription agency, XS Typing UK, using their encrypted file upload system. Once completed, the manuscripts were returned by email to the lead researcher. The data received was reviewed by the researcher. Each interview was listened to alongside the transcription and the manuscripts were edited where necessary. The edited manuscripts were then uploaded to a computer based qualitative analysis software package (QSR NVivo 10) in order to begin the analysis of the data.

2.5. Ethical considerations

The procedure raised a number of ethical issues that were considered in advance of the interviews being conducted. There is no formal framework for approving research conducted in the context of Children's Social Care services. As the participants are all staff employed as professionals in Leeds Children's Social Care services, they were recruited as research participants by virtue of their professional role. Approval to conduct the research was received from the Deputy Director of Children's Services in Leeds, following a summary of the proposed research. This approval was received in the form of a letter from the Deputy Director of Children's Services in Leeds on 7th August 2015 (appendix 7). A formal ethical review was sought from the University of Leeds Research and Innovation Department. This was submitted to the School of Medicine Research Ethics Committee and approval was granted on 14th September 2015 (appendix 6). Below is a summary of the key ethical issues and how they were addressed by the lead researcher.

2.5.1. Consent

The participants were given an information sheet (appendix 4) that informed them of the context of the research and the potential usage and implications of the findings. They were asked to sign a consent form as a record of consent (appendix 5). The participants were given an opportunity to withdraw from the interview up until the transcription began with no negative consequences.

2.5.2. Confidentiality

All information was audio recorded in private rooms where only the participant and researcher were present. The participant information sheet (appendix 4) ensured that all participants were informed about how the information obtained would be used following the interview.

2.5.3. Anonymity

The data was audio recorded using a Dictaphone from the University of Leeds. The digital audio files anonymised by being randomly assigned a number from zero to twenty. The data is presented here anonymously using pseudonyms that were assigned once the transcribed file was returned from XS Typing UK. Where the content of the data obtained enabled identification of a specific individual, it was omitted or adjusted.

2.5.4. Harm to others

The interviews lasted between 31 and 78 minutes (*mean* = 51 minutes) and all participants were given the opportunity to rest during the interview. The participants

were given the contact details of the researcher so that they could raise any concerns that they may have had following the interview. Participants were encouraged to seek support from their peers, managers, union or independent providers if they experienced distress during or following the interview process.

2.5.5. Harm to self

The researcher ensured that there was adequate time between the interviews to recover and sought support from the research supervisors about the experience of conducting the interviews.

2.5.6. Data storage

Data was stored electronically on the secure server at the University of Leeds and the data files were password protected. The audio recordings were uploaded to XS Typing UK using their encrypted file upload system. The original data recordings will be stored on a secure server at the University of Leeds for at least five years following submission of the final thesis, which will occur in May 2016.

2.6. Analysis

Pseudonyms were assigned to all manuscripts and the participants' professional grouping was retained for use in the analysis (i.e. Tanya: pseudonym, MST-CAN: professional group). The manuscripts containing the transcribed interviews were then uploaded to QSR NVivo 10. The responses that participants gave to the interview questions were recognised as data for use in the analysis (Massey, 2011). Thematic analysis (TA) was selected as an appropriate methodology to identify, analyse and report patterns within the data (Table 1). This allowed the

researcher to organise and describe the data in detail and interpret the findings in relation to the concepts associated with collaboration in the context of child social care (Boyatzis, 1998). TA was chosen because the data was collected in one sample and because the approach allows flexibility in the analysis, incorporating both inductive and deductive approaches (Hayes 1997). The analysis produced a number of key and sub-themes that were linked to the data collected (Patton, 1990).

The researcher followed a systematic approach to analysing the data using TA, which was developed by Braun and Clarke (2006; Table 1). This method of analysis consists of six stages. The first stage involved the researcher familiarising themselves with the data through the process of transcription, re-listening to audio recording and re-reading the transcripts. As the researcher had the interviews transcribed externally, extra time was spent during this process of familiarisation and all of the transcribed interviews were edited in line with the audio recordings. During this stage of the analysis, the researcher began noting initial ideas that help to describe the data set.

The second stage of analysis involved generating initial codes from the data set. The researcher read through each interview using QSR NVivo 10 and began to code the data from the participants' responses. These codes were descriptive initially and enabled the researcher to begin to establish patterns that existed within the data set by developing each of the codes. In the third stage of analysis, the codes were developed into potential themes that described the data more broadly. Initially the themes were descriptive and the researcher began to establish which of the coded data would fit within the themes.

The fourth stage of the thematic analysis involved reviewing the themes. The researcher began to generate a map of the analysis by establishing if the themes related to the coded data across the data set. At this stage, a more interpretive analysis

of the data began to emerge as the themes were developed. The fifth stage of the analysis involved defining and naming the themes. The themes were considered in relation to the data that the represented and appropriate names and definitions were chosen for each theme. The themes were developed in a way that enabled the story of the data to be told.

The sixth and final stage of the analysis involves producing a report of the results. Through this process, the analysis was presented to and reviewed by the research supervisors and the themes were refined further to ensure that the analysis provided clear, interesting examples from the data and that the analysis related to the research question. The report formed the results chapter of the thesis. The table below shows how the data from the interviews was developed into the final themes using Braun and Clarke's (2006) model.

Data extract	Stage 2: generating initial codes	Stage 3: Descriptive theme	Stage 4: Interpretation of the theme	Stages 5 & 6: Defining and naming theme
'sometimes services are introduced and then some services go away like they lose their funding and then they go but are replaced by something else or with a different name and sometimes it can be confusing'	Abandonment Replaceable Temporary Confusion	Uncertainty about how long a service will be around	If the service isn't sustainable it may not be worth committing to	Key theme: *Committing to the intervention* Sub theme: *Sustainability of the intervention*
I guess a challenge more for other team members, not necessarily for me, was the fact that it's a temporary contract, so people want to make it work because they need to have a job basically'	Temporary Need the service to be effective	Uncertainty about if the service will work		
'My feeling was 'is it going to be around in another year? Are we going to be, not investing our time in it, but is it going to be a service where in a year's time it's gone?'	Temporary Waste of time Abandonment	Uncertainty about how long a service will be around		

Table 1. Example of data analysed through the phases of thematic analysis, adapted from Braun and Clarke (2006).

2.6.1 Alternative methods of analysis

Thematic analysis (TA) was chosen as the preferred method of analysis as it differs from other approaches that seek to describe patterns across the data. In deciding on the most appropriate form of analysis, Interpretative Phenomenological Analysis (IPA) and Grounded Theory (GT) were also considered as possible alternatives. However, they were deemed as less suitable for this analysis for a variety of reasons, which are considered below.

When using IPA, the researcher aims to understand the participant's experience of their day-to-day reality in greater detail (Holloway and Todres, 2003). This is different to the aim of the research described here, which was to broadly understand the experiences of collaboration between MST-CAN and social care practitioners to identify important parts of the process. The difference in approaches is illustrated by how the IPA researcher and the TA researcher begin the process of analysis. The IPA research makes initial notes for each individual item and interview, whereas the TA researcher begins the analysis by familiarising themselves with the entire data set (Smith, Flowers & Larkin, 2009). In addition, the IPA approach determines what theoretical framework should underpin the research whereas TA allows consideration of multiple potential theories and a more flexible approach to the analysis (Larkin, Watts & Clifton, 2006; Braun & Clarke, 2006).

There are multiple varieties of GT with a range of theoretical underpinnings and associated procedures (Birks & Mills, 2011). Traditionally, the GT researcher does not engage in the relevant literature prior to undertaking the analysis to avoid any findings being shaped by their preconceptions (Glaser & Strauss, 1967). GT attempts to use theoretical sampling in order to produce a useful theory from the data obtained (Charmaz, 2002). The generation of a theory is beyond the remit of this

thesis and would not have been necessary to answer the research questions. When grounded theory is not applied in the more traditional sense, it has been described as 'grounded theory-lite' and can produce very similar results to TA as it does not generate a novel theory at its conclusion (Pidgeon & Henwood, 1997). GT is associated with a prescribed analytical approach that dictates the method of data collection and analysis (as with IPA) whereas TA does not have a prescribed method of data collection. The versatility and flexibility of TA meant it was well suited as the method of analysis for this research study. This versatility was also recognized by Braun and Clarke (2006), who suggested most qualitative analysis is essentially a form of TA that is labeled as something else.

2.7. Credibility and quality checks

In order to ensure credibility and quality of the research, a number of steps were taken as recommended by Elliott, Fischer and Rennie (1999).

2.7.1. Quality check of transcriptions

The researcher listened to each of the audio recordings and edited the transcription received from XS Typing UK. This ensured that the text representing the data was as accurate as possible. This process also enabled the researcher to begin familiarising themselves with the data as recommended by Braun and Clarke (2006).

2.7.2. Research supervision

The researcher attended frequent supervision sessions during the process of analysis. Following the analysis, the key findings were explored with the research supervisors and this process was used to establish the final themes of the results.

2.7.3. Audit trail

Information regarding the researcher's thoughts about the analysis was developed in using the memos function in QSR NVivo 10 in order to allow development of the key themes and subsequent reflection and interpretation of the data. Some of this information is presented above in Table 1.

2.7.4. Grounding the data

The researcher ensured that each interpretation of the data was grounded within the quote data and other similar samples of data (Stiles, 1993). Table 1 provides an example of how the data was developed into the final themes that were presented.

2.8. Researcher influence

It is inevitable that our experiences and knowledge influence our perspective on the research that is undertaken (Yardley, 2008). As a result, it is important for qualitative researchers are able to be aware of their own potential for bias in understanding the data in order to monitor and account for any potential problems. The lead researcher had previous experience of working within social care teams and had a sense that social work practitioners have a difficult job to do because of the increased caseloads, lack of support and because they are held responsible for the failings of the muti-disciplinary team. This understanding was part of the reason that the researcher decided to undertake this research. The researcher was aware of this potential bias and ensured that they responded consistently with all respondents so that they did not influence their responses, particularly when participants spoke about

the difficulty of working as a social work practitioner. The researcher also discussed their experiences of conducting the research with two research supervisors. To some extent this, early experience of working alongside social care may have enabled the researcher to have a better understanding of the role of social work practitioners and helped to inform their approach to understanding the data.

CHAPTER THREE: RESULTS

The aim of the research is to explore the process of inter-professional collaboration between social work and MST-CAN practitioners when an evidence-based intervention for child abuse and neglect is introduced. In particular, the researcher attempted to understand which factors have helped or hindered the process of collaboration in this context, rather than determining if the collaboration was successful or not. Here I present three key themes that emerged from the thematic analysis which describe factors that help or hinder the process of inter-professional collaboration between social work and MST-CAN practitioners when working together to deliver the MST-CAN intervention in Leeds Children's Social Work Services. The three key themes are 'adapting the intervention to the cultural context', 'committing to the intervention' and 'working together to deliver the intervention'. When the MST-CAN intervention was introduced into Leeds Children's Services, it had to be adapted to fit the local context and MST-CAN practitioners had to commit to the intervention before they could begin working together. The process of collaboration developed throughout these stages.

There are ten subthemes that describe the factors that helped or hindered the process of inter-professional collaboration, in more detail. Sharing of information was central to the process of collaboration and served a function in a number of the subthemes discussed here. For example, participants gave examples of when sharing information with a colleague helped to facilitate the process of leadership, managing expectations and developing trust between social work and MST-CAN practitioners. Although sharing of information is not a theme in itself it could be considered as a broad theme that is relevant to the process of collaboration. The key themes and associated subthemes are presented in a thematic map

(figure 1) and a detailed description and interpretation of themes is provided in the subsequent text, along with data from the interviews.

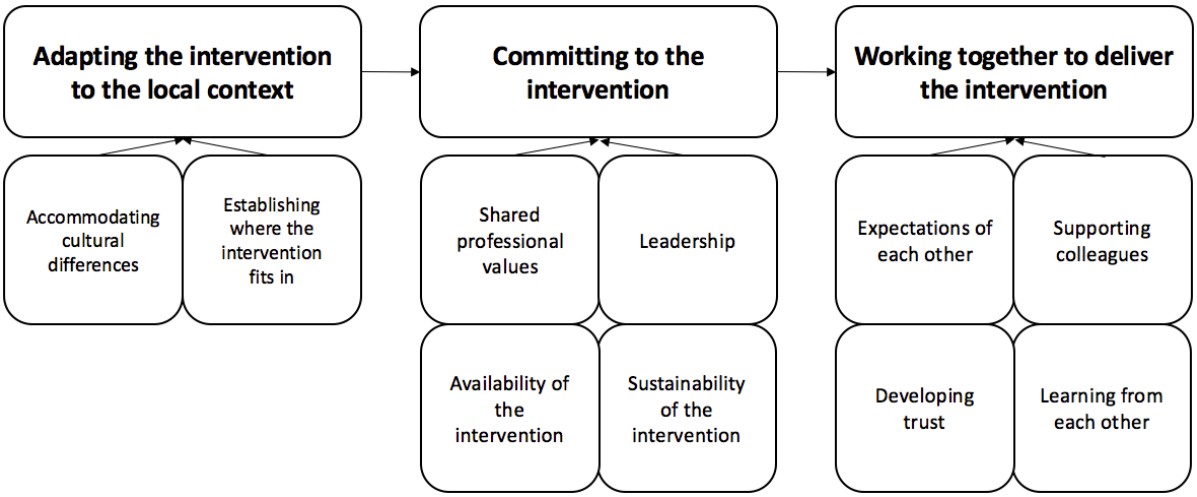

Figure 1. Thematic map to show the analysis of the semi-structured interviews completed with social work and MST-CAN practitioners working in Leeds Children's Social Work Services.

3.1. Adapting the intervention to the local context

For an evidence based intervention to be implemented into different contexts it needs to be adapted to the individual needs of the service. Participants spoke about how, for MST-CAN, there was a process of understanding how the intervention should to be adapted from the US to the UK context, as the service was initially developed in the US. These adaptations involved accommodating the cultural differences in the UK that had to take place before collaboration could begin. Participants also spoke about how understanding how MST-CAN would 'fit' into the local organisational context was crucial. In particular, it was important to avoid duplication of services and to avoid misunderstanding and confusion that could have made collaboration more difficult. Both of these adaptations had to be considered in order to

facilitate collaboration between MST-CAN and social work practitioners. In some instances, adapting to the local context hindered the process of collaboration and in others it resulted in more communication and a shared sense of challenge for the social work and MST-CAN practitioners. The two subthemes are presented in more detail below.

3.1.1. Accommodating cultural differences

MST-CAN was developed in the United States and was therefore designed for the North American health and social care system, which has a number of cultural differences to the UK. The differences between US and UK contexts include access and provision of services, treatment of employees and referral thresholds. The differences between these cultural contexts meant that the MST-CAN practitioners had to address some difficulties in translating the intervention from the US to the UK. This impacted on collaboration because a number of unexpected differences had to be addressed before the MST-CAN practitioners could begin working with the social work practitioners. Tanya commented on the difference between healthcare systems. In particular, she spoke about how provision of psychiatry is different in the US.

> *'There's something about how things translate across the pond really so the MST CAN team has a part time psychiatrist in it and I guess my take on it is the reason they have that in the States is because psychiatry is quite hard to come by in the States because their health system is so different to ours' (Tanya, MST-CAN)*

Tanya went on to elaborate on the broad range of issues that had to be considered in light of the different context in the UK. She spoke about how the number of holidays that

MST-CAN practitioners would have in the UK would mean that they were less able to carry out an intervention as consistently.

> *'how we work with this population, how we treat our employees, how much holiday we have, you know all those things impact on the model because in America they have very little holidays, very few holidays whereas here some of these workers have got so many weeks' holiday' (Tanya, MST-CAN)*

This is important to the process of collaboration for two reasons. Firstly, because these issues had to be addressed before the collaboration could begin, which will have delayed the initial part of the process. Secondly, because the model was developed in a context where MST-CAN practitioners had very few holidays, the increased amount of annual leave that UK based MST-CAN practitioners have may impact on the quality of the collaborative relationship because it will be difficult to maintain the same level of consistency that the practitioners had in the US. Tanya also spoke about the impact of this difference between cultures on the intervention. This has implications for collaboration because it would be difficult to collaborate consistently if the therapists are on leave or become unwell.

> *'if you've only got three therapists which this team has and one of them goes off you're pretty much stuffed' (Tanya, MST-CAN)*

Lucy, spoke about her perceptions of the difference between how somebody might be determined as suitable for the service in the US and how that is different to her experience in the UK. In particular, she spoke about the lack of clarity about when a child is deemed to

have been abused. It was her sense that the doctor has more authority in the US and identifying abuse was more clear. However, in the UK the decision is often the responsibility of the social worker. This could impact on the collaboration between social work and MST-CAN practitioners because ambiguity and uncertainty about key issues introduces a sense of doubt that needs to be resolved before they can proceed with a sense of agreement. Conversely, this uncertainty could also provide an opportunity to facilitate collaboration because the social work and MST-CAN practitioners could negotiate these difficulties together, through the process of collaboration.

> *'A clear incident in America is very clear, they are much more black and white, it's like if the doctor says this child has been hit, that's it. It has. Whereas here it's sort of like 'Well it could be a non-accidental injury' and the families are very good at saying 'Absolutely not!' so things are not as clear, it's just all a bit - it's quite hard sometimes to work it out' (Lucy, MST-CAN)*

There is a broader level of adaptation that must occur between the US and UK, as mentioned above, and there are cultural differences within the UK systems. These differences are evident between health and social care and within social care. As a result, the intervention needs to be translated to the local, organisational culture within each Leeds Children's Services team, of which there were over 30 teams working in three localities. Louise spoke about how it was important to her to establish the individual aims and outcomes of the team from the beginning of the intervention. This facilitated collaboration because the social work and MST-CAN practitioners have an opportunity to develop a shared understanding of these aims and outcomes. This will also form a basis for future collaboration between MST-CAN and social work practitioners.

'it's having to adapt to each team, where they're at in terms of what they're looking for, so it's really important to establish right from the start what their outcome is' (Louise, MST-CAN)

Lucy spoke about how local cultural differences within Leeds Children's Social Work Service meant that there was a discourse about how families may receive a different service in different areas. These cultural differences can include what the professionals within the service value, the language that they use to describe families and their procedures for care. This has implications for the process of collaboration because the MST-CAN practitioners will have to adapt their approach to each team and negotiate their expectations based on the team's previous experiences.

'"Oh, they'd have been in care if they'd have been in west." So, it's really established they are different just because of the amount of kids and the amount of referrals, I guess, they get in different areas' (Lucy, MST-CAN)

Translating MST-CAN from the US to the UK context and subsequently within the individual teams within Leeds Children's Services had its challenges. This impacted on the collaboration between professionals in that it meant that a number of unforeseen problems had to be addressed before the collaboration could begin. Consistency between colleagues and agreements about key concepts had to be established in order to provide a solid foundation for future collaboration and to enable social work and MST-CAN practitioners to consistently deliver the intervention and avoid any avoidable confusion or uncertainty about how the two groups will work together. How the MST-CAN practitioners facilitated this

process was not always clear and given more time to review the themes during the interview process, the researcher would have asked more questions about what they found helpful in overcoming these challenges. The next sub-theme describes how MST-CAN and social work practitioners were able to work together to establish where MST-CAN fitted into the broader service structure.

3.1.2. Establishing where the intervention fits in

For the MST-CAN practitioners to collaborate effectively with the social work practitioners in delivering the intervention, it was important to establish where the MST-CAN service fits within the existing service structure. This helps to avoid misunderstanding and duplication of work that could negatively impact the inter-professional collaboration. Nadia reflected on the amount of time that she invested in developing relationships with social services and other local services, through various meetings and how it was important to establish these relationships so that other services were aware of MST-CAN and to begin the process of understanding where they fit in. This facilitated collaboration with MST-CAN because forming these relationships was the basis of their collaborative relationship and helped to avoid confusion.

> *'There is a lot of sort of networking when we set up…we went to talk to the legal team who deal with care proceedings. We went and talked to all the different drug services, lots of different agencies just to introduce ourselves really and get to know what, you know, basically show our faces so people knew who we were' (Nadia, MST-CAN)*

Alice's experience of this liaising with other services was positive. She felt that most services were willing to meet and discuss the intervention with the MST-CAN practitioners

because the service was unique and not like anything that was available in Leeds. Opening a dialogue with services was essential in developing a collaborative relationship that involves a shared understanding with these services and crucially, with the social work practitioners.

> *'people were willing to meet with you and hear about the new service, and hear about how it was different to everything else in Leeds at that time, 'cause it is very unique' (Alice, MST-CAN)*

This sense of the intervention being unique was echoed by some of the social work practitioners. Melanie spoke about how the intervention is holistic in a way that other services that are available are not. It is likely that social work practitioners were more likely to want to work with the service because they felt it was offering something that other services were not.

> *'there is not really a service in Leeds that does that work as intensively as they do and does sort of the holistic stuff, there is drugs and alcohol focusses but they don't look at the rest of the family situation' (Melanie, Social Work)*

However, this process was not straightforward as there was some confusion of roles, particularly when developing relationships with drug and alcohol services because of the similar ways of working between MST-CAN and these services. In particular, both MST-CAN and drug and alcohol services use Reinforcement Based Treatment (RBT) when supporting a parent with addiction and behaviour change. This was potentially a problem in the collaborative relationship with social work practitioners because it could have led to confusion and misunderstanding about the role of MST-CAN.

'I think it was a struggle with the substance use agencies at first, because of the RBT, the side of work that we do and, sort of, how we would work, how they would work, and whether it would work in partnership or not'
(Alice, MST-CAN)

This difficulty was also linked to how the intervention required other professionals to 'step back' and allow the MST-CAN practitioner to coordinate the care for the family. For MST-CAN to fit into the existing service structure it involved a change in roles for other professional groups. This was a potential problem for collaboration with social workers because they were one of the agencies that were also required to step back and this may have made collaboration between social work and MST-CAN practitioners difficult.

'whilst MST came in and expect other agencies to step back a bit, maybe substance use agencies or other supports, social care in school was, kind of, non-negotiable'
(Alice, MST-CAN)

MST standard was well established in Leeds as a part of the services that were available as it had been around since 2008. Nadia spoke about how MST standard was an intervention that was well known across the services in Leeds.

'it's almost a brand MST a bit, it's a bit of a people know it, people know it across the city' (Nadia, MST-CAN)

MST-CAN is an adaptation of MST Standard and both approaches are often referred to as 'MST'. This lead to some confusion about the difference between the two types of intervention and difficulty in understanding what MST-CAN had to offer that was different to MST Standard. There were also a number of expectations that were associated with the brand of 'MST'. Joanne spoke about how she and her colleagues were unsure if MST-CAN was different from MST standard. This confusion about what MST-CAN practitioners do and what the intervention offers made the process of collaboration difficult in the first instance as there was a lack of clarity about what the two professional groups were working towards.

> *'we knew about MST, it was up and running, off the ground going and then it's got a little, another word next to is hasn't it? So we're like well is it MST and what's that about?' (Joanne, Social Work)*

Some of the allied services in Leeds covered a large area so it may be that one part of the service became aware of MST-CAN before another did. This is a potential problem because of the relatively small size of the MST-CAN team and the large area covered by children's social care and allied services in Leeds. It was difficult to ensure consistent awareness of the service and as a result, consistency in collaboration with the social work practitioners was difficult. Tanya spoke about how the MST-CAN service had a good relationship with police and acknowledged the difficulty of ensuring consistency in the response from police officers.

> *'we've got a really good relationship with some police in some areas but again Leeds is so big to kind of engage the whole police service in conversation' (Tanya, MST-CAN)*

Ensuring awareness of MST-CAN within these agencies is important as they often hold positions of power in relation to a family. In particular, the police are able to place the children into care quickly, which is often the opposite of what the MST-CAN and social work practitioners will be trying to achieve through their work with a family. In order to ensure that MST-CAN and social work are able to collaborate it is important that the relationship to the police is carefully managed. Tanya spoke about how being assertive with agencies such as the police is particularly important.

> *'It means they can put them into care in that moment, which is the thing we're trying to avoid all the time whereas they can just go, "I've had enough of chasing this kid, they need to [go into care]" and you're like, "No."'*
> *(Tanya, MST-CAN)*

The inconsistency in awareness of MST-CAN and variation in willingness to engage with services working with families is also a feature of relationships within the education system. Tanya spoke about some of the difficulty in engaging with schools consistently. This will also make consistent collaboration between MST-CAN and social worker practitioners difficult.

> *'I think other systems are more difficult so more distal systems but more powerful systems so school is a big one. Again in some schools and education faculties are brilliant and some just don't even want to know' (Tanya, MST-CAN)*

However, a shared experience of the challenge of working with schools could enable a closer relationship which may support collaboration. For example, it would allow a shared sense of experience and empathy through working to develop relationship with schools together. Louise spoke about how when other agencies are involved it is important to notice how each service 'fits in' to the package of care for a family. In doing so, the MST-CAN therapists are able to involve social care, police, schools and adult mental health services in the intervention with the family. Louise also spoke about how because of the intensive intervention from MST-CAN, they are the ones required to negotiate where the other services fit into the intervention. The social work practitioners are required to trust the MST-CAN team to co-ordinate care and that would usually be their responsibility.

> *'Adult mental health is another area because of course sometimes they'll have their own adult mental health worker, or is it something that we can do because we are an umbrella agency so then sort of like negotiating that and how you fit it all in' (Louise, MST-CAN)*

Collaboration between MST-CAN and social work was facilitated through understanding where MST-CAN fits into the existing service structure. Despite the efforts of team members to network whilst the intervention was being set up, there was confusion of roles and an inconsistent awareness of MST-CAN with some agencies. This was an ongoing challenge and one that the MST-CAN practitioners had to address in order to ensure a collaborative relationship with the social work practitioners. The MST-CAN practitioners were able to do this through assertiveness and through taking the lead in coordinating the role of other services once they had received a referral from the social work practitioner. The process of understanding where MST-CAN fits in was also facilitated through

communication between the two services and communication with each other and with external organisations in order to gain an understanding of where the MST-CAN intervention fits in.

3.2. Committing to the intervention

In order for collaboration to occur, it is important that the professionals who are working together are able to commit to delivering the intervention. In the case of MST-CAN, participants spoke about how sharing values with the intervention and each other, and leadership, helped to facilitate this commitment. For some participants, concerns about availability and sustainability of the intervention made it difficult to commit and the MST-CAN and social work practitioners had to overcome these initial concerns in order to facilitate the collaboration. The subthemes presented in this section clearly relate to factors that help (shared professional values and leadership) and hinder (availability and translatability of the intervention) the process of collaboration. These four subthemes are presented in more detail below.

3.2.1. Shared professional values

A number of participants spoke about how the values and principles of MST-CAN appealed to them and matched their own professional values. For Michael, MST-CAN was an approach that embodied restorative practice. Restorative practice is a collaborative, empowering approach that, amongst other things, enables families to repair relationships. From Michael's perspective, Leeds Children's Services were already working with restorative practice and the introduction of MST-CAN was further evidence that the organisation was committed to this way of working. For Michael, this showed that Leeds Children's Services was going above and beyond what was required of a social care team.

This formed the foundation for collaboration between social work and MST-CAN as Michael was more willing to work with the MST-CAN practitioners because he held the values that underpinned the intervention.

> *'what I found in Leeds is that we bought into a vision, if you want, and part of that vision was about restorative practice. As part of the whole restorative practice approach it appears that Leeds thought: yeah, let's invest in particular services. I bought into that, even as a student really, especially when I made the choice then to apply for Leeds…that's what I felt I needed out of social work, it wasn't the mundane, do this, do that, go home and do the same again. It was really pushing the boundaries, and I felt like, the MST service, when I first heard of it, was possibly something that was doing that' (Michael, Social work)*

The restorative approach to a family of the MST-CAN practitioners was also valued by other social work practitioners. Sarah spoke about how she values the approach because she has seen the results of the intervention in empowering people who may have otherwise struggled to find their voice. This is important in collaboration between social work and MST-CAN practitioners because the social work practitioners are more likely to invest in the collaboration if they share an experience of success after investing in something that they value.

> *'I find it a really restorative approach, which I'm a massive fan of, and it's helped this woman find her voice, really, it's been really positive' (Sarah, Social Work)*

This experience was echoed by Melanie, who spoke about how the approach was empowering and enabled the mother in the family to make and maintain positive changes in her life. Again, this was important in the process of collaboration as the social work practitioners are more likely to invest in the intervention if they have seen evidence of success.

> *'it was about empowering mum to make the changes she needed and being able to maintain those over a period of time and that worked' (Melanie, Social Work)*

Social work practitioners also value the importance of equality in their work. In order to commit to the MST-CAN intervention, it was important that social work practitioners felt that the approach enabled an equal relationship between them and the MST-CAN practitioners. Sarah spoke about how MST-CAN focuses on addressing power imbalances in the relationship and how this matched with her professional values. This helped to facilitate successful collaboration between Sarah and the MST-CAN practitioner that she was working with because she valued that aspect of the approach.

> *'with MST [CAN], it's more of an equal relationship where we're unpicking things and planning things together, and that's really, really valuable for me as a practitioner' (Sarah, Social Work)*

MST-CAN practitioners share a number of the values that social work practitioners do. Alice spoke about how she valued the approach of restorative practice, which was important in forming the foundation of her collaborative relationship with social work practitioners. This was evident in how Alice described her decision to apply for a job as an

MST-CAN therapist. She spoke about how the principles of MST-CAN and the approach to families motivated her to apply for the job and the importance of restorative practice.

> *'I interviewed for the MST-CAN 'cause I just really liked the principles and the way they thought about working with families in the restorative practice, and everything that came with it. That was just really appealed to me' (Alice, MST-CAN)*

Louise, who previously trained as a social worker and had re-trained as an MST-CAN practitioner, echoed this. She stated that the principles of MST-CAN allow her to work in the way she wanted to as a social worker, using a collaborative, restorative approach:

> *'it also meets why I wanted to be a social worker in the first place and offering work to a client group that I'm interested in' (Louise, MST-CAN)*

There were some specific examples of how restorative practice is empowering for the families using the service. Alice, spoke about how open questions rather than telling people the answer is part of this approach and something that she values.

> *'it comes from them, rather than us telling them: this is what the problem is, we're asking them opening: what do you think's contributing to it? And I think that is really empowering for people' (Alice, MST-CAN)*

However, it was not always the case that the professionals would share the values of the intervention. When this was the case, it could have made collaboration difficult because the MST-CAN therapist was seen as working in a way that was unhelpful and even harmful

for the family. Nadia spoke about how the social work practitioners saw the MST-CAN practitioners as colluding with the family because they were working to keep the child within the family rather than looking for evidence to remove the child from the family. This rupture to the collaborative relationship could result from the social work practitioner investing in an approach to a family and feeling challenged by an alternative way to work with the family.

> *'they can see us as almost colluding with the parents, when we're not, we're just working with them and joining them… rather than looking at 'come on then let's catch you out and find out and find enough evidence to get your kids into care' (Nadia, MST-CAN)*

When professionals had a different approach and did not share the values of the intervention, Lucy spoke about how she tried to balance the relationship with the social work practitioners and the family she is working with in order to ensure that neither group feels that she is aligned more with the other:

> *'one of the main things is trying to not to have a coalition with a social worker or a coalition with the client and often you can feel that you're trying to balance that' (Lucy, MST-CAN)*

Tanya summarised the importance of values, that are considered above. For her, matching values makes it more difficult to achieve the outcomes that they would want for a family who is receiving the intervention.

'it's very value led so everybody wants the same thing so it becomes quite easy to achieve that if that makes sense' (Tanya, MST-CAN)

Social workers have a strong set of professional values and if collaboration is to be successful, social work professionals have to believe that the intervention that is being implemented embodies these values. For social work practitioners to collaborate in delivering the MST-CAN intervention it was important that the values and ways of working that underpin the MST-CAN intervention, matched their own. If this was not the case, collaboration was more challenging. The particular values discussed here was restorative practice and working equality in relationships. This is an important component of what helps collaboration as sharing these values lays the foundation for future partnership wokring. It could also be likely that if the professional believes that interventions should be restorative and collaborative, this will also influence how they approach their professional relationships.

3.2.2. Leadership

The initial stages of collaboration are helped by effective leadership. Leadership is the process of motivating and inspiring others and effective leadership can help to create an environment that is amenable to change. This is particuarly important when a new intervention, such as MST-CAN, is being introduced. Participants identified leaders as key facilitators that pioneered the implementation of MST-CAN and those who promoted the service locally. Leadership facilitated collaboration because the MST-CAN and social work practitioners had an increased level of motivation and felt able to work together to deliver the intervention. Tanya, spoke about how she valued her experience of leadership from a colleague who was part of the team that was involved in MST-CAN being implemented in Leeds children's services. In particular, she described this person as a capable and focused

leader.

> '*he's a really, really big advocate for MST, a major champion really, he's been around since the beginning of MST. He's the one who championed the expansion of MST…he's a really strong leader so he's very clear on what he wants' (Tanya, MST-CAN)*

The influence of other key facilitators was evident for other MST-CAN practitioners. For example, Alice spoke about how her experience of seeing an MST-CAN expert talk about the intervention motivated her to reflect on her work and to ensure that she was doing her job as an MST-CAN practitioner to the best of her ability. This experience of leadership facilitated collaborative working because Alice was more motivated towards developing in her role. One part of this development required investing in the collaborative relationship with the social work practitioners.

> *'when you are here and an expert talks about what it should look like, it does make you think: I need to do this in this way… I think it just makes you reflect as well on what you need to do to grow into the role, and make sure you're doing the job well' (Alice, MST-CAN)*

Leadership from key facilitators in social care was important and their primary role in the leadership process was the dissemination of information to social work practitioners. Provision of information was evidence that these key facilitators were committed to and knowledgeable about the intervention, which helped to create a working environment that was amenable to progressive change. Sarah spoke about how the information about MST-CAN came to her from her manager. This was important in providing a foundation for future

collaboration between social work and MST-CAN practitioners in delivering the MST-CAN intervention.

> *'it came down from management. So our managers have a fortnightly managers meeting, so all the managers meet fortnightly, and then our managers will then go through what was talked about at those meetings with us' (Sarah, Social Work)*

This was echoed by Adam, who also provided information about the intervention from his team manager.

> *'My manager told me about it. I think there was an email around and my manager told me about it that a new service has been commissioned' (Adam, Social Work)*

An important aspect of leadership is provision of information because it creates an environment that can facilitate meaningful change, such as the implementation of a new intervention. Although the information from social work managers increased awareness of the service, Melanie spoke about how there was not enough information about how the service would work in practice. It was when an MST-CAN practitioner spoke to the team that this became clearer. This leadership was important because it gave some context to the service and the collaboration that would occur between the social work and MST-CAN practitioners working to deliver the intervention.

> *'I think service delivery manager at first sort of gave what information they had but in the initial stages it wasn't all clear how it was going to work but certainly the therapist who came to the team meeting was very knowledgeable and gave us a lot of*

information and I think she answered all the questions at the time, so yeah, she was very helpful' (Melanie, Social Work)

Louise suggested that the introduction of MST-CAN to the teams could have been facilitated more formally and frequently. She proposed that structured, two-hour sessions that would enable consistent provision of information across all parts of Leeds Children's Services. This would help with collaboration because the information would be provided directly form the MST-CAN practitioners and any questions about the service could be asked immediately. This process, although more time consuming, may improve consistency of the service

'you [could] do like a couple of hours of MST awareness, so anybody can come on to it to find out more about the service, so that's a good thing, getting the information out across the children's services generally'
(Louise, MST-CAN)

When asked about the process of leadership, Louise also spoke about how the meetings when information could be shared were important and another key component was in the day to day leadership that the MST-CAN and social work practitioners would be able to facilitate through delivering the intervention.

'the steering group and the meetings with managers, so yes, listening to it all, so that is all part of the leadership isn't it but it's very much pushing the therapist's out there to lead it' (Louise, MST-CAN)

There was evidence that leadership was successful because of the enthusiasm that was shared amongst social work practitioners. When a social work practitioner had collaborated with the MST-CAN practitioner in providing the intervention for a family, their enthusiasm for the intervention was shared with their colleagues. Joanne and Sarah spoke about sharing information about their experience of working with MST-CAN with their colleagues. In particular, they spoke about how they would encourage their colleagues to refer to MST-CAN. This is important in relation to collaboration because when the social work practitioner hears about a colleague's positive experience, they are more likely to want to work with the MST-CAN practitioners.

> *'people would say 'oh how's that going with that?', 'Oh it's brilliant', 'Oh how do you refer in?' So people would ask me just because they knew I had a family [working with MST-CAN]' (Joanne, Social Work*)

> *'I communicate that to my team members all the time, you know, if they're talking about a case, I'll say: why don't you give MST-CAN a ring? They'll say, oh no. And I'd say, honesty give them a ring, they might have the capacity, they might...you know' (Sarah, Social Work)*

Leadership is important if the MST-CAN and social work professionals are to be motivated towards the intervention and to create an environment that is conducive to change. Key facilitators that were seen as pioneers or experts were important in the leadership of the MST-CAN intervention and included those involved in introducing the service and managers who delivered information about the intervention to social work practitioners. When a social work practitioner had worked with an MST-CAN practitioner in delivery the intervention,

they were then more willing to share information within their own team. This helped to facilitate the process of collaboration because the leadership meant that staff were aware of positive experiences of colleagues having collaborated with MST-CAN. What the leaders that delivered MST-CAN did to facilitate collaboration was not always clear and given more time to review the themes during the interview process, the researcher would have endeavoured to understand this process in greater detail.

3.2.3. Availability of the intervention

The MST-CAN team had limited capacity and could only take on nine cases across all of Leeds Children's Services per nine-month intervention cycle. This led to sense of unfairness for some of the social work practitioners. This lack of availability did not fit with their belief that a service should be made available to a large number of families rather than a select few. As a result of this, the social work practitioners may have been reluctant to collaborate with the MST-CAN practitioners in delivering the intervention. Sarah spoke about how she felt like there was very little chance of the case she proposed being accepted because there are thousands of cases and only three referrals that will be accepted per children's social care team.

> *'we've got three wedges in Leeds, we've got the south, the east and the west, and it was like we'll be able to take three cases from each wedge, and that was a bit like, well we've not got a chance in hell then, because there are thousands of cases and we're gonna' work with...no chance' (Sarah, Social Work)*

The reason for this perception for a high demand for the MST-CAN intervention was outlined by Michael. He spoke about how MST-CAN offered a level of intensity and reassurance for the social work practitioners that no other intervention does.

> *'there's no other service that offers that level really, the intensity and reassurance' (Michael, Social Work)*

Having a shared understanding of barriers to an intervention is important and can facilitate collaboration. Melanie shared this sense that the service would not be able to meet the needs of all of the children who required it. She also acknowledged that the intensity of the intervention required the MST-CAN team to have smaller caseloads in order to fulfil their role in the collaboration. This perspective would have helped in the process of collaboration between the social work and MST-CAN practitioners because there was a shared understanding of the challenges the intervention, which is an important part of the collaborative relationship.

> *'resources are limited in that they can only take on a certain case load to enable them to take on the kind of work that they do so I suppose that would be the difficult part of it' (Melanie, Social Work)*

The lack of availability led to some uncertainty about how decisions about referrals were made. The anxiety created by this had a negative impact on the process of collaboration because the social work practitioners felt powerless and that they had to go above and beyond the usual process of referral in order to ensure that the family who they had been working with were able to have the MST-CAN intervention. Michael spoke about how he felt he had

to do whatever he could so that the family were seen by the MST-CAN service and how the reason for accepting the referrals was unclear to him.

> *'It's almost like beg, steal or borrow to try and get the family on board. They go into panels; they're choosing: why's this family more prioritised over that family?' (Michael, Social Work)*

This point was echoed by other social work practitioners who wanted the MST-CAN intervention to be provided to families that they had been working with. Joanne spoke about her surprise when she heard that five families were put forward as appropriate for MST-CAN service and only two spaces were available.

> *'I really want that service. And she was like this might work, and I was like 'oh God' and she said 'we've got five families in mind and only two spaces'. I was like 'oh my God'' (Joanne, Social Work)*

There was a lack of clarity about how the decision to accept referrals for MST-CAN was made. As a result, the sense of unfairness about which families would be receive the MST-CAN intervention prevailed even after the referral was accepted. For example, Joanne spoke about how it was her belief that the family she had been working with had been offered the intervention because she was more vocal and persistent than her colleagues. Although Joanne, was pleased to have had a referral accepted this could have impacted negatively on potential future collaboration with Joanne's colleagues for whom a referral was not accepted.

> *'I think I begged the loudest. I think yeah' (Joanne, Social Work)*

Similarly, this lack of clarity around the decision making process led some people to feel that they had been lucky in having a referral accepted by MST-CAN. Louise compared having a family accepted to winning the lottery. As with Joanne, had Louise not had a referral accepted it could have had a negative impact on any future collaboration. However, it could also be that colleagues hearing that the referral process had the same limited probably would have made it less likely that they would make a referral to MST-CAN in the future.

> *'I think somebody described it sort of like "Oh you've got MST-CAN, it's like winning the lottery"' (Louise, MST-CAN)*

There was a sense that if the service could be offered to more families than there would be more positive outcomes for the children who are at risk of abuse and neglect. Melanie spoke about how this was something that she considers and this discontention is crucial in her sense of availability.

> *'sometimes you just think if more families had access to that, would there perhaps have been more positive outcomes for them' (Melanie, Social Work)*

The reasons for this lack of clarity about the intervention process were considered by Melanie. She said that the communication with MST-CAN practitioners before the referral was accepted was not adequate to inform her understanding of the process. As a result of this she sought out the MST-CAN team manager to consider the appropriateness of the referral. This was a helpful process for her and Melanie had taken the lead in establishing the collaborative relationship with the MST-CAN practitioners.

'I don't think there was so much communication in the early stages in terms of discussions about referrals and I had a conversation with the team manager and that was particularly helpful in just talking through the case and see if it was appropriate for them to take on' (Melanie, Social Work)

Linda spoke about how she felt that the family were questioned too frequently about their willingness to work with the intervention. She felt that she had worked hard so that the family would agree to take part and felt that the cautious approach to accepting the referral meant that the family then decided that they did not want to take part. This means that the intervention could not be completed with this family. This would impact on the process of collaboration because Linda had a negative experience of MST-CAN and may be less willing to refer in the future. She may also be less likely to recommend the intervention to her colleagues.

'once the parent had got to the point of agreeing to this service to then be repeatedly asked if that is really what they wanted and then they said no it wasn't'
(Linda, Social Work)

Social work practitioners value fairness and the limited availability of the MST-CAN intervention meant that there was a sense of unfairness and uncertainty in the referral process. This is likely to have impacted on collaboration because of the sense of powerlessness that the social work practitioners experienced in relation to this process. The social work practitioners felt that they had to go above and beyond what would usually be accepted so that a referral to be accepted. However, the social work practitioners interviewed all eventually had their referral accepted, so were eventually pleased with the outcome of the

referral process and were willing to engage in the process of collaboration. However, the lack of availability of the service and uncertainty about the referral process may negatively impact the process of collaboration for social work practitioners who did not have a referral accepted at that time but may do in the future. It could be that they are less willing to make a referral in the future.

3.2.4. Sustainability of the intervention

In addition to MST-CAN only being available for a small number of families, the social work practitioners were also concerned about the sustainability of the intervention. To some extent, the social work practitioners were reluctant to invest in the service because they were unsure that it would be around for a long time. There were concerns from both social work and MST-CAN practitioners about how worthwhile it would be to invest in the MST-CAN intervention. The service was commissioned on a short-term basis so there was no guarantee that it would continue past the first nine-month cycle. Tanya spoke about how, from an MST-CAN perspective, there were concerns about how sustainable the service was in relation to costs, operational challenges and the size of the team. Tanya was also concerned about how the service could be developed for sustainability whilst still remaining true to the intervention model. This is important in relation to the process of collaboration because if both social work and MST-CAN practitioners have concerns about how sustainable the service is, it may make it more difficult to focus on delivering the intervention together.

> *'It needs a bit more unpicking if we're going to sustain in this MST CAN, particularly in terms of the cost of it and just the operational challenges of it and the team is so small and how can we begin to do something about that and still keep MST CAN' (Tanya, MST-CAN)*

Melanie spoke about her sense of uncertainty about sustainability of MST-CAN. She was aware that previous interventions had been introduced before losing funding, being withdrawn and/or replaced. She spoke about how this concern was not specific to MST-CAN but more generally reflects the socio-political context of Children's Social Services. This previous negative experience impacted on Melanie's willingness to collaborate with MST-CAN practitioners at the beginning of the intervention.

> *'sometimes services are introduced and then some services go away like they lose their funding and then they go but are replaced by something else or with a different name and sometimes it can be confusing that is not specific to MST-CAN, I think that is generally with a lot of services that we work with' (Melanie, Social Work)*

This sense of a general scepticism around new services was echoed by Linda. This further reflects the importance of past experiences of the social work practitioners on their willingness to collaborate.

> *'we're all by nature a bit sceptical about new services and what they actually do' (Linda, Social Work)*

Joanne expressed her concerns about whether MST-CAN was a service that she should invest her time in. Social work practitioners have large caseloads and limited time so have to carefully choose how they spend their time. It was Joanne's perspective that in talking about the potential issues of sustainability, MST-CAN practitioners had created a negative impression of the intervention. This could have impacted on her decision to

collaborate with MST-CAN in delivering the intervention because this investment would have been less worthwhile is the service was not around one year later.

> *'My feeling was 'is it going to be around in another year? Are we going to be, not investing our time in it, but is it going to be a service where in a year's time it's gone?' when it actually sounded like a really good service, so I think they almost sold themselves negative really' (Joanne, Social Work)*

This reluctance was not only experienced by the social work practitioners. Lucy had anticipated the social worker's concerns about sustainability and could understand their reluctance to invest in the MST-CAN service. Her perception that people will not be willing to invest in the collaboration with MST-CAN could have led to some difficulties in the early stages of the collaborative relationship.

> *'there's so many teams across so many social work teams and so many different agendas and I guess we only have twelve spaces and people heard it and thought oh right yeah' (Lucy, MST-CAN)*

The uncertainty about how sustainable the service impacted on some of the MST-CAN practitioners in relation to their job security. Nadia spoke about how the temporary contract for MST-CAN meant that she felt pressure to ensure the service was viewed as successful because poor outcomes would potentially mean that she and her colleagues no longer had a job which created a sense of uncertainty about sustainability of the service and of her role as an MST-CAN practitioner. This is likely to have added pressure to the

relationship that she had with the social work practitioner and impacted on her motivation towards collaboration.

> *'I guess a challenge more for other team members, not necessarily for me, was the fact that it's a temporary contract, so people want to make it work because they need to have a job basically' (Nadia MST-CAN)*

Leeds Children's Services were not the only UK based team to implement MST-CAN but the teams set up in two other services had been discontinued. This meant that at the time of interview, the MST-CAN service in Leeds was the only one in the UK. Louise had some understanding of the reasons that the other services were discontinued and this fuelled her sense of uncertainty about sustainability of the service and of her role as an MST-CAN practitioner. This could have impacted on her motivation towards collaborating to deliver the MST-CAN intervention.

> *'When we started there was a team in Cambridge and a team in Greenwich, both of those have closed down. I think the Greenwich team just lost its funding, I don't think that was… that was just short term funding and cutbacks is my understanding there. Cambridge decided that, the programme manager there decided that she didn't want to do that anymore' (Louise, MST-CAN)*

Similarly, Nadia spoke about how her experience of the other MST-CAN teams before they were discontinued had influenced her perception of how sustainable the Leeds service would be. She noticed that the team she visited had recruited using a different method which may have contributed to how successful it was. It may be that this interpretation of the

other team as different was protective for Nadia as she was able to see the Leeds MST-CAN practitioners as different. This helped her to maintain her enthusiasm for the intervention and in collaboration with the social work practitioners.

> *'we did go down for one supervision with the Greenwich team but they all seem quite despondent some of them had been seconded, but they had been redeployed into the CAN team from CAMHS, they didn't necessarily want to be there' (Nadia, MST-CAN)*

In order for social work and MST-CAN practitioners to commit to the process of collaboration that is required in delivering the intervention it is important that the service is worth investing in. Social workers are used to change and inconsistency in service delivery and if they perceive an intervention as unsustainable they were less likely to want to collaborate. Uncertainty about sustainability of MST-CAN was voiced by both social work and MST-CAN practitioners and this will have most likely made collaboration more difficult initially because of a reluctance to engage or an increased pressure to ensure collaboration was successful for job security. The uncertainty is unavoidable to some extent as it was related to past experiences of how services are introduced and then subsequently removed from services. For social work practitioners, understanding how this intervention was different to others helped in maintaining enthusiasm towards the MST-CAN intervention despite the inherent uncertainty. In order to overcome this potential barrier to collaboration it was important that the MST-CAN practitioners demonstrated their commitment to the intervention. They did this by supporting social work practitioners and developing trust in their work together, which are key components of the next key theme.

3.3. Working together to deliver the intervention

The MST-CAN intervention had to be adapted to fit the local context and MST-CAN practitioners had to commit to the intervention before they began working together. The process of adapting the intervention to the local context meant that collaboration was delayed but also provided opportunity for the social work and MST-CAN practitioners to work together to understand where the service fitted in. In relation to committing to the intervention, participants spoke about two factors that helped collaboration: shared values and leadership and two factors that hindered the process of collaboration: concerns about availability and sustainability of the intervention. This theme focuses on the processes that helped to overcome some of the difficulties in the collaborative relationships as it began to develop as the MST-CAN and social work practitioners began to work together to deliver the intervention. Managing expectations, developing trust, supporting colleagues and learning together were all processes that helped to facilitate collaboration by overcoming potential challenges. These subthemes are considered in more detail below.

3.3.1. Expectations of each other

In order for the social work and MST-CAN practitioners to collaborate successfully, it was important for them to establish what they expected from each other. When they were aware of the expectations of the service they were able to meet them when possible and to consider alternatives when not. This process was similar to understanding where the intervention fits in, however, the focus in this theme is on the social work practitioners' perspective rather than the understanding of the service in the wider context. For example, social work practitioners were familiar with other family interventions but MST-CAN offered a different type of approach. This difference was commented on by Lucy, who highlighted how MST-CAN was much more intensive and more therapeutic than other interventions.

This difference in expectations could have impacted on the process of collaboration in that there may have been preconceptions about what MST-CAN would offer as an intervention and how the MST-CAN and social work practitioners might work together.

> *'I guess social workers are very used to family intervention phase, it's really established in Leeds, so they're used to that, so okay what's the difference? There's massive intensity, it's more therapeutic' (Lucy, MST-CAN)*

Joanne spoke about general uncertainty about the MST-CAN intervention and what the MST-CAN practitioners do as part of their role. It was her sense that the intervention felt secretive and misunderstood. This lack of understanding and sense that MST-CAN was secretive would have impacted on the process of collaboration because the social work practitioners did not know what to expect of the MST-CAN practitioners.

> *'there are a lot of myths and secrecy around MST. And then people are like, well are they social workers? Well no they're MST. Well what does that mean?' (Joanne, Social Work)*

Working with MST-CAN involved a change in responsibility for the social worker. The social work practitioners become the statutory lead for family for the duration of the intervention and the MST-CAN practitioners become the clinical lead. This means that although the social work practitioners identify the key problems for a family, the MST-CAN practitioner carries out the intervention. Social work practitioners were unsure about what to expect from this change in role and it led to some uncertainty and confusion about who would lead with the case. Adam spoke about how he was unsure if he could hand over

responsibility of leading the intervention to the MST-CAN practitioner as he would typically manage the care plan for the child and family. Uncertainty about expectations of these roles may have gotten in the way of working together to deliver the intervention.

> *'I think they wanted to take the lead but ideally because the plan is managed by the social worker and is being coordinated by the social worker it's the social worker's role to be the lead agency' (Adam, Social Work)*

Joanne felt that her role as a social worker was pre-determined and that she would remain as the professional lead for the group of professionals who are working with the child and their family. This may have been different from the expectations of the MST-CAN practitioners and would have been negotiated in order to facilitate the collaboration between the two professional groups.

> *'from memory you have to be on Child Protection Plan to get MST, you can't…you've got a very clear role as a social worker, because it's statutory. You visit every 15 workings days. You're leading the core group so you've got a very clearly defined role that no matter who is involved with that child, you have to lead the core group' (Joanne, Social Work)*

MST-CAN practitioners spoke about how they felt it was important to be clear about their role in the intervention, particularly in their interactions with social work practitioners. It was Alice's experience that the social work practitioners had to be reminded that they still had a duty of care to the family and that they couldn't become less involved because the family was working with MST-CAN. This was important in order to ensure that the MST-

CAN and social work practitioners were able to negotiate these expectations as part of their collaboration.

> *'I think it's just been very clear from the start of your role. Being clear with yourself, being clear with social care and what your role is, and that their role hasn't ended, they still have their duty of care to do - and just making that clear to the family' (Alice, MST-CAN)*

Alice spoke about how, in her experience, being allowed to take the lead with clinical work led to a better outcome for the intervention. This is further evidence that there was a difference in expectations about who would be the clinical lead with the family and this had to be negotiated before the intervention could begin, in order to facilitate the process of collaboration.

> *'where it's worked well is that social care are on board, and they allow you to take clinical lead and, you know, they work with you' (Alice, MST-CAN)*

Nadia also spoke about negotiating expectations in order to ensure that both social work and MST-CAN practitioners were able to take responsibility for their part of the intervention. Nadia also spoke about the importance of understanding these expectations in the context of the social work practitioner's role. She spoke specifically about how social work practitioners have much higher workloads and how she adjusted her expectations of them accordingly.

'So I guess it's finding that balance of having urgency and being able to work on what you need to work on now and making sure the social workers is taking responsibility for their part in it. But then understanding we have three cases they have loads and that they can't always just drop everything to do what we need to do. So it's finding that balance with them' (Nadia, MST-CAN)

It was important for the social work and MST-CAN practitioners to understand each other's roles. It was also important to understand the broader context of the intervention. Melanie spoke about how she would have liked more information to help with her understanding of the bigger picture of the MST-CAN intervention, which would have helped her understand what she could expect from the MST-CAN practitioners. A lack of understanding could make it difficult to establish expectations of the service and may have made collaboration more challenging.

'It could be useful to know in terms giving a context to the whole situation and know where it comes from. Any information is probably useful to have, just have a better understanding sometimes it is helpful to know what to expect from a service' (Melanie, Social Work)

There was an idea that MST-CAN was restrictive and inaccessible service and it was only though opening up a dialogue that the social work practitioners understanding and expectations of the MST-CAN intervention changed. Sarah spoke about the importance of encouraging her colleagues to contact MST-CAN in managing the expectations of others. This information is important in establishing an effective collaborative relationship between the two professional groups.

'sometimes people can get the impression that MST is really very prescriptive, and really quite strict in terms of what they'll work with. But, actually by communicating with them more, and encouraging people to pick up the phone and give them a ring, see what they say' (Sarah, Social Work)

The expectations of colleagues were also managed by Joanne, who had a similar experience in that her colleagues asked about her experience of working with MST-CAN. This had a cumulative effect as information was passed on between colleagues and provided a foundation for future collaboration between Joanne's colleagues and the MST-CAN practitioners.

'it became word of mouth, once I'd started working with them other team members were 'who are you working with? And what are they doing? And what does that mean? How does that work?' So it became a bit of a snowball effect in our office (Joanne, Social work)

Social workers have demanding caseloads and want to use their time as efficiently as possible. It was important that expectation of the service was managed before the referral was made because time social work practitioners would not want to spend their time completing a referral form for MST-CAN if the family were not suitable for the intervention. Linda spoke about how important this was for her and reflected on her experience of spending time filling out referral forms in the past

'There is nothing more frustrating for social workers than filling out lengthy forms and then being told it is the wrong service' (Linda, Social Work)

Providing information in advance helps to manage expectations and begins a process of collaboration in positive way. It was Michael's experience was that he was given information about the referral process, which helped him to manage his expectations of the service.

'they've come in and spoken to us at a team level, and spoken to us about the grass-roots referral level, and things like that' (Michael, Social work)

Knowing what to expect from a new service is important in forming the basis for collaborative relationships. Participants spoke about the uncertainty about who undertakes which role when delivering the MST-CAN intervention led to some difficulty in understanding what to expect from each other. The social work practitioners found that understanding the broader context of the intervention was important in managing expectations. Once a social work practitioner had been involved in an intervention they were able to help their colleagues manage expectations of the service through describing their experience. It was particularly important that the expectations of the referral process were managed in order to ensure that time was spent efficiently given the workloads of the social work practitioners.

3.3.2. Developing trust

For collaboration to be successful, trust needs to be established between professional groups. Trust is particularly important in delivering the MST-CAN intervention because it is

introduced when a family is not making progress and the social work practitioner may feel they hold responsibility for this. As mentioned above, the social work practitioners become the statutory lead for family for the duration of the intervention and the MST-CAN practitioners become the clinical lead. As a result, the intervention requires the MST-CAN practitioners to take more responsibility for the clinical work and the social work practitioners to have less responsibility at a time when the family is in crisis and the child may be about to be removed from their family home. This could have made it difficult for the social work practitioners to trust that the MST-CAN practitioners would be able to facilitate a change that they were so far unable to do. Michael spoke about how he effectively felt that the MST-CAN practitioner was doing his job but he still had a professional responsibility towards the family. He spoke about how communication with the MST-CAN practitioner helped him to feel more comfortable with this change in role. This was important for the process of collaboration because the communication that Michael and the MST-CAN practitioner developed enabled them to work together to deliver the intervention.

> *'Somebody else is doing your job, but you are still responsible, so how do you deal with that? And the only way you can satisfy yourself with that is by the good communication part. If you don't know what they're doing, there's something broken down somewhere' (Michael, Social Work)*

As well as ensuring that communication is good, it is also important that the MST-CAN practitioners are able to include the social work practitioners in delivery of the intervention if they are to develop trust. This is important in establishing a collaborative relationship when the two professional groups are working together to deliver the

intervention. Sarah spoke about how she felt that working with MST-CAN enhanced her practice because she felt included in the intervention.

> *'in terms of my experience with MST-CAN, the balance in that has been just right, because it's helped my practice, it's not made me feel like I've been pushed out and I can't do anything, it's been very much a partnership, which is what it's meant to be' (Sarah, Social Work)*

There was evidence that communication between professionals was important in collaboration and facilitated a trusting, collaborative relationship between the two professional groups. Joanne, spoke about how feeling that the MST-CAN practitioner understood what was important to her, helped her to begin the work collaboratively to deliver the intervention.

> *'from how she spoke she got it, she knew what I was, and that settled me and then we did a joint visit to the family. And I just knew she knew what she doing, beyond that she got my trust off we went' (Joanne, Social Work)*

As described above, the MST-CAN intervention often begins when a child is likely to be removed from their family. Tanya, spoke about how the MST-CAN practitioners often have to address the challenges within the family as well as within children's social care. Part of this 'battle' is establishing the trust of the other professional groups as they may already be committed to the children being removed from their family home.

'I think one of the big challenges for the CAN team are about where the social worker quite often these cases have gone a long way down the legal road in terms of we are about to take these children away and when CAN go in there's already a commitment to take the children away so for CAN to go in and try to keep the children there, they are not only battling the challenges that already exist in that family, they're battling all the systems too' (Tanya, MST-CAN)

Tanya went on to describe how she sees the social work practitioner's perceptions of what might happen around the time of the MST-CAN intervention. In particular, she spoke about how the social work practitioners will identify a child as needing to go into care and following the MST-CAN intervention, they do not. This may make it difficult for the social work practitioners to trust in the MST-CAN practitioners as they may feel undermined or betrayed by them. This would impact on the process of collaboration as the social work practitioners may be less willing to work with the MST-CAN practitioners.

'imagine that. You made a call these kids need to be taken into care and then the service go in and actually they don't' (Tanya, MST-CAN)

This point was echoed by Nadia. She spoke about how mistrust can develop as a result of the positive outcomes following the MST-CAN intervention. The social work practitioners may not trust that the outcomes are what they are claimed to be because the social work practitioner has worked hard and not been able to make the same level of progress with the family.

'They're feeling like, what the hell do I do with this family? They're never going to change. And then we go in and then within a few months we're seeing change, they're probably a little bit mistrustful or either are we making it up or are we not seeing it or are we not noticing it?' (Nadia, MST-CAN)

Some of the MST-CAN practitioners had a background as social work practitioners and were able to use those pre-established links in order to establish trust from social work practitioners that they knew from the past. Although this was not essential in establishing a collaborative relationship, for Nadia, this made collaboration easier because the social work and MST-CAN practitioners could build on these existing relationships which formed a solid basis for their work together.

'I already had links there, so that was really good because people knew me and they knew, they'd worked with me before so they knew I wasn't just some random person coming in doing some weird intervention they'd never heard of' (Nadia, MST-CAN)

For the social workers to trust the MST-CAN practitioners it was important that they the MST-CAN practitioner had a background in working on the front-line with families. In this case, trust is based on the idea of a shared experience between the social work and MST-CAN practitioners. Joanne spoke about how when she knew that the MST-CAN practitioner had direct experience of working with families, she felt that she would be better able to understand the difficulties in working with families. This was important in developing trust and underpins the collaborative relationship that the two professionals developed.

'she wasn't just from this nice posh service, that's expensive and is throwing a bit of money about. She knew she must have at some point knocked on doors. And that's really valuable when you're a social worker 'cause that's somebody else understands that, how intricate families can be really' (Joanne, Social Work)

In order to facilitate trust it was also important to share in the challenges of delivering the intervention. Lucy spoke about how social work practitioners can often feel that they are responsible for any risks with a family and in order to establish trust, it is important to share the risk and responsibilities of the family. This is important in the process of collaboration because sharing responsibility of risk enables a sense of partnership and shared purpose.

'We're there every day. Just managing that really because I guess it's that shared social care feel that they're carrying the risk. We need to be… Well, actually, we're carrying it too' (Lucy, MST-CAN)

Developing trust is an important aspect of developing a collaborative relationship. In the context of the MST-CAN intervention, trust is particularly important. This is because the social work practitioners have to relinquish responsibility for clinical care to the MST-CAN practitioners and because the intervention takes places when the child may be about to be taken from their family home. The MST-CAN practitioners have to gain the trust of social work practitioners to show that they are capable of carrying out the intervention and in being honest about the outcomes, which may be better than expected. Existing relationships between MST-CAN and social work practitioners and the perception of shared experience facilitated trust in the MST-CAN practitioners from the social work practitioners. Sharing

responsibility and openness in communication was important in establishing trust in capabilities of the MST-CAN practitioners.

3.3.3. Supporting colleagues

Working in the context of children's social care is challenging. As discussed in chapter one, social work practitioners often have unmanageable caseloads and can carry the responsibility of failings within the multi-professional team. This is particularly difficult in relation to child abuse and neglect where there is increased pressure to identify and respond appropriately to children who are in need of support. This leads to increased anxiety about the introduction of new services and as a result, MST-CAN practitioners were able to provide support for the social work practitioners in managing their anxiety in order to facilitate the collaboration. The MST-CAN practitioners had the time available to do this because of much smaller caseloads. This was an important part of the collaboration between the social work and MST-CAN practitioners because potential difficulties in the relationship could be managed by the MST-CAN practitioners. Tanya spoke about how in relation to high risk cases there is anxiety associated with concerns about the case that they're working with. This often results in social work practitioners seeking reassurance. Tanya spoke about how the MST-CAN practitioners are able to contain this anxiety through being open and receptive to their concerns. When an MST-CAN practitioner is able to empathise with the social work practitioners experience in this way it helps to facilitate a collaborative relationship with the social work practitioner.

> *'Obviously if we've got like a really high risk case they really want to work with you then 'cause they're scared and everybody so everybody wants to be talking about the same thing and I think we're good at that' (Tanya, MST-CAN)*

Other participants shared this experience of anxiety that the social work practitioners experience. Nadia spoke about how the anxiety associated with risk meant that people will often talk in excessive detail about a case in an attempt to communicate their sense of urgency. Again it is important that MST-CAN practitioners are able to contain this distress and empathise with the social work practitioners in order to develop a shared understanding of the difficulties that a family is experiencing.

> *'it's like almost vomiting of information all over you because they're so desperate to tell someone. Because again they're frightened for these children and they're worried about them so they want to make you understand how bad it is' (Nadia, MST-CAN)*

Joanne speculated that this anxiety and increased pressure on social workers was the result of the recent failing in social care in the UK. She spoke about the specific case of Baby Peter, a two-year-old boy who died as the result of parental abuse in the UK in 2007, despite being known to health and social care services for a number of months. The death of Baby Peter was primarily attributed to failings in communication within social care.

> *'Health visitors, everybody… wants to tell you about their visit and maybe that's post baby Peter that everybody wants to tell you. Yeah if I've told the social worker those children will be safe' (Joanne, Social Work)*

The clinical skills of empathy and emotional containment help the MST-CAN practitioners to facilitate a collaborative relationship with the social work practitioner, in the way that they would develop a therapeutic relationship with members of a family using the

service. Lucy spoke about her experience of empathising with the social work practitioner was similar to how she would work with a family who were distressed.

> *It's almost like treating the social worker as a client as well as the family, what will fit best so we're likely to ring them at different times or… And offering that "I appreciate it's really difficult for you' (Lucy, MST-CAN)*

Lucy went on to elaborate about how engagement and rapport with the client were an important part of the process of supporting the social work practitioners. She also spoke about how she spends time with social work practitioners understanding what a good outcome would be and what their frustrations with a family are.

> *'just like you get the engagement and the rapport with the client and you getting in and you're finding out where they are and what they're desired outcomes are and understanding their frustrations, you almost have to do that therapy in the first few weeks with the social worker because they're so exhausted and fed up with this client a lot of the times' (Lucy, MST-CAN).*

This similar way of working was also shared by Tanya, who spoke about how she often finds similarities in her approach with families and the skills that she uses when working with social work practitioners. These skills enabled Tanya to facilitate a collaborative approach to the intervention.

> *'I think on a professional level since I started working in social care I feel myself working with social workers the way I would work with a family' (Tanya, MST-CAN)*

The reason for this increased level of anxiety relates to how social work practitioners want the best for the children that they work with. Nadia spoke about how understanding that social work professionals are worried about the wellbeing of the children is important. For her, this shared understanding is important in the process of collaboration.

'it's because people have the best interests of these kids at heart and they're frightened for them, they're worried about them' (Nadia, MST-CAN)

Social work practitioners shared this sense in relation to how they perceive the MST-CAN practitioners. They also perceived them as wanting to make a difference to the families that they work with, despite the intervention being a very challenging process. This is important in the process of collaboration because there is a shared understanding between the inter-professional groups which will form the foundation of successful collaboration.

'I think they are hugely committed people, caring people who want to make a difference and are in a very difficult position' (Louise, MST-CAN)

The skills in forming therapeutic relationships were helpful when working with the social work practitioners. Other aspects of the MST-CAN approach were helpful for MST-CAN practitioners in developing a collaborative relationship with the social work practitioners. In particular, Louise spoke about how the FIT problem solving method (which helps a practitioner to understand how different systemic factors impact on a particular problem) allows her to consider how she can manage her own frustration with the social work practitioners in order to work collaboratively with them.

"the 'fit' is helpful when you sort of think about the frustration with other professionals because it is very easy to just feel frustrated with the professionals and then not do an awful lot about it apart from carrying a resentment around which isn't very affective. Social actually do a FIT in on it and think "right how am I going to work on improving this partnership working?" (Louise, MST-CAN)

As part of a restorative approach towards the family using the MST-CAN service, the MST-CAN practitioner will often challenge existing discourses about the family. This challenge is often made by changing the focus from the more challenging to the more positive aspects of a family. Nadia spoke about how she does this when working with social work practitioners in order to facilitate a change in their understanding about the family. The aim of this is to ensure a restorative approach from all professionals involved. Ensuring a restorative approach to a family is an important part of collaboration because the MST-CAN practitioners are challenging the existing discourse in a way that allows the social work practitioner to integrate it into their existing knowledge base rather than directly challenging it.

'And then also putting on what's good because to try and help focus on you know that there are positives in this family, they're not all bad' (Nadia, MST-CAN)

Lucy reflected on how professionals will often share in their difficulties working with a family in a way that is unhelpful. For her it is important for the MST-CAN practitioner to challenge the discourses in the way discussed by Nadia and also to encourage collaborative discussion with the family present wherever possible.

'what is really interesting is if you go to a core group meeting and the family do not attend, the conversations in that meeting is far different from its parent attended because it becomes very much a coalition of how difficult this family are and everybody gains that shared experience of what a nightmare family they are' (Lucy, MST-CAN)

The MST-CAN practitioners spoke about how the narratives that exist about a child or family can lead to a misinterpretation in some instances. Nadia spoke about an example of when a child was given a better breakfast in school if she said she had not had any at home. This led the child to tell school she was hungry even if she had eaten. Because of the narrative around the family, this was interpreted, as the child is not being fed without any exploration of alternative reasons for the child's behaviour.

'she'd been told at school you'll, if you're ever hungry come and ask us and we'll get you breakfast; she'd get a bacon sandwich. She learnt that if I tell them I'm hungry I'll get a bacon sandwich and a cup of tea and not to go to my first lesson. She doesn't realise that then gets noted down and put on, raised in a Child Protection meeting about her parents not feeding her' (Nadia, MST-CAN)

It is often the role of the MST-CAN practitioner to challenge the language used in communication in an attempt to challenge the existing narrative. Taking an honest, curious response, Lucy spoke about how she will do this when all parties are present in order to ensure a collaborative approach to communication in difficult circumstances.

‘“The children came and their unkempt.” I might say “What does unkempt mean?” and the parent’s there and they feel really awkward’ (Lucy, MST-CAN)

Louise spoke about her experience of challenging existing discourses about a family. In particular, a curious questioning approach helped her to understand how other professionals perceive the family. She spoke about how this use of language was a problem and was something that she has to address in order to develop a collaborative relationship with the social work practitioners.

‘often you hear “Oh a mums got a serious mental health issue” and I’m like “Oh right well what are they?” It's like “I’m not quite sure what they are but they are very serious, I don’t think we can work with them…” sort of like huge huge problems sort of thing’ (Louise, MST-CAN)

Sarah also spoke about how she valued the approach of the MST-CAN practitioners in providing support for the MST-CAN practitioners. In particular, she perceived their approach as systematic in nature. This is important for the process of collaboration because if the approach towards working together is seen as valuable, the social work practitioners are more willing to collaborate.

‘I think it's the systematic approach, it really helps me, it works for me and it's worked for the family really, really well’ (Sarah, Social Work)

Melanie found that she had more time to reflect on the intervention during the MST-CAN intervention because the MST-CAN practitioner takes on a co-ordinating role within

the team. This is important for collaboration because the social work practitioners experience was that working with the MST-CAN practitioners allowed them a luxury that they would not have been able to afford when working with other families.

> *you have more of an opportunity then to reflect on what is going on because you are not constantly embroiled in the daily goings on of the family, so think it gives you a bit more of a chance to reflect on things' (Melanie, Social Work)*

Working in children's social care in the UK professionally challenging and social work practitioners often have unmanageable caseloads and carry the responsibility of failings of the multi-professional team. This results in increased level of anxiety about certain cases. The MST-CAN practitioner is able to use their intervention skills when working with the family and social work practitioners, in order to develop an empathic, collaborative relationship; to problem solve when they experience difficulties within the collaborative relationship and to challenge the existing discourses about a family in a way that is none-threatening. This is essential in maintaining an effective collaboration with social work practitioners and MST-CAN practitioners are able to do this because of their training, small caseloads and because they have more available time.

3.3.4. Learning from each other

An important aspect of the process of collaboration is a shared experience of learning. Although there was no formal process for the social work and MST-CAN practitioners to learn alongside each other, this process occurred naturally through working together to deliver the intervention. This shared experience of learning was an opportunity to develop

and strengthen the collaborative relationships as it enabled the social work and MST-CAN practitioners to develop their understanding of the intervention process. Alice spoke about how she and the social work practitioner were able to celebrate the positive outcomes of the intervention together. Similarly, they were able to learn from the parts of the intervention that hadn't gone well. This shared experience enabled them to strengthen their relationship as part of the process of collaboration.

> *'sometimes you get really good outcomes and you can really celebrate those together. And then when things haven't gone so well, I think it's just an opportunity to learn why (Alice, MST-CAN)*

Sarah gave a specific example of something that she had learnt from the MST-CAN practitioner from being involved in the intervention. In particular, she noticed how the clarity, consistency and regularity of the communication were helpful in enabling the mum in the family to make changes in her life. This was important for the process of collaboration because the social work practitioners are more willing to collaborate if they see that the intervention is effective and would be more likely to invest in the intervention in the future.

> *'by being so clear, so consistent, and so intensive, the MST work has built an amazing relationship up with the mum, and now she's unrecognisable as the woman that we had a couple of months ago' (Sarah, Social Work)*

Joanne spoke about how she was able to use some of what she learned in her work with other families. In particular, she spoke about how she would tend to be more structured and boundaried in the time she spent with families. She went on to talk about how the more

creative ways of working were valuable in her work following the MST-CAN intervention. This positive learning experience was important in the process of collaboration because Joanne may have been more willing to collaborate if she saw that the intervention was effective and would be more likely to invest in the intervention in the future.

> *'there was something about being very structured these are our times together, so I did borrow that and push it into some families that I'd worked with and will take with me really. But you do that when you do collaborative working, you do pinch things that work. I'll have that. Absolutely… I can get mum and child involved with', I only need a bit of card and some glue in my bag, I've got felt tip pens and stuff in my kit anyway. So very quick fixes that could do' (Joanne, Social Work)*

Sarah spoke generally about how working with the MST-CAN intervention had been positive for her and not led her to feel de-skilled. Instead it had led her to wonder what factors had made a difference to the mother in the family. This receptive and open approach from Sarah may not have been shared by other social work practitioners. If a social work practitioner felt de-skilled by the intervention, it may have impacted negatively on the process of collaboration.

> *'it's not made me feel de-skilled at all, it's made me think: oh, I wonder what the difference has been? Maybe it's a combination of things, it's the approach, it's the personalities, it's the fact that the mum was at a time where she was ready to make a change, and all those things have just come together really well for us to make progress' (Sarah, Social Work)*

Michael spoke about how what he's learnt from MST-CAN will influence the work that he does in the future. In particular, he spoke about how the work with the MST-CAN practitioners will shape his work. Michael spoke about how developing good relationships, whilst showing empathy would enable him to guide the work that he does with families in the future.

> *'you kind of think I want to be that person who is working with that family, has that good relationship, has that sort of empathic response to them, who they look to be the person to try and sort of guide them along the way kind of thing'*
> *(Melanie, Social Work)*

As with any professional group, the social work practitioners were at various stages in their career. Michael spoke about how he was receptive to this experience of learning because he was in the early stages of his career. It may have been that social workers with more recent training were more receptive to learning from the MST-CAN practitioners. This is important in the process of collaboration because there may have been a difference in the experience of more established and more recently qualified social work practitioners.

> *'it has helped me stay on track, and it will shape my social work in the future. 'Cause I'm only two years in so, yeah, hopefully I've got years and years and years to go. So, yeah, hopefully that will always be there' (Michael, Social Work)*

The idea that social work practitioners who were more recently qualified were more receptive than those who had been qualified for a number of years was shared by Nadia. Her experience was that younger, more recently qualified social work practitioners were more

excited to engage in the intervention and those who were more experienced were less enthusiastic about the intervention. It was Nadia's sense that this also meant that more established social work practitioners were focused on finding evidence of a family's problem than working restoratively with them. This is important in relation to collaboration because more experienced social work practitioner may have been less willing to work and learn from the intervention, which could have made collaboration more difficult. Also, the preconception that Nadia had formed may have impacted on her willingness to collaborate with social work practitioners whom she perceived to be less enthusiastic about the intervention.

> *'it's a bit of a generalisation but the sort of newer younger social workers tended to be more excited and more on board with is and more sort of really into you know wanting this to work for this family…More sort of established social workers who have been doing it a long time were more in that mind set I guess with people becoming a bit more jaded, and this wasn't the case for all everyone, but would be more looking at finding evidence to catch families out' (Nadia MST-CAN)*

MST-CAN practitioners work in a way that is different from social work practitioners. In particular, they are trained to deliver the MST-CAN intervention which is an approach to working with a family that involves a high level of therapeutic skill. The social work practitioners were able to learn from this approach, which helped to strengthen the collaborative relationship. In thinking about why the intervention worked, the social work practitioners spoke about how they were able to apply ideas around structure, clarity, consistency, empathy and creativity, amongst others in order to support future families to change. This is important for the process of collaboration because the social work

practitioners will have a positive experience of collaboration and will be more likely to want to collaborate in the future. In addition to this, they will be more likely to describe the intervention more favourably with their colleagues. Willingness to engage in this process of learning may have been different for social work practitioners depending on their level of experience. This difference may have led to differences in the process of collaboration.

CHAPTER FOUR: DISCUSSION

4.1. Research aim

Despite the impact of child abuse and neglect on the abused child, their family and associated costs to society, there are a limited number of evidence-based interventions (EBIs) available (Simeroff, Seffer, Baldwin & Baldwin, 1993; Wang & Holton, 2007; Chaffin & Friedrich, 2004). In addition to the lack of available EBIs, there is little guidance for how such interventions should be introduced into existing services, which results in a gap between research evidence and clinical practice (Bodenheimer, 1999). Research focusing on what factors are important in introducing EBIs into the context of children's health and social care have identified a number of important factors, such as: planning the EBI; staff training; collaboration between professionals; evaluation and adapting to feedback. From these factors, the focus has most commonly been on collaboration. The current research aimed to add to the existing literature about professional experiences of collaboration, in the context of children's social care. The researcher explored the process of inter-professional collaboration between social work and MST-CAN practitioners who were working together to deliver the MST-CAN intervention to families in Leeds. The aim was to answer the following research question:

> *What factors help or hinder the process of inter-professional collaboration between social work and MST-CAN practitioners when a specialist intervention is introduced?*

4.2. Summary of research findings

Collaboration is defined as "bringing together individual providers and practitioners with a common sense of mission and the collective resources to achieve it" (Brandon, 1996, p.323). Collaboration often involves sharing of ideas and information and collective action towards a shared goal (D'Amour et al., 2005). In relation to the process of collaboration, there were three key themes that emerged from the analysis of the data: 'adapting the intervention to the local context', 'committing to the intervention' and 'working together to deliver the intervention'. These three themes describe the process of how collaboration developed as MST-CAN was introduced into Leeds Children's Services; the intervention needed to be adapted to fit the local context and MST-CAN practitioners had to commit to the intervention before they could begin working together. There were a number of factors that helped and hindered the process of collaboration, which are summarised below.

Sharing information was an important component of a number of key themes i.e. 'understanding where MST-CAN fits in', 'leadership', 'managing expectations' and 'developing trust'. Although it was not an individual theme, sharing of information was considered as a broad theme that facilitated a number of other sub themes. This finding echoed previous research which found that found that there was a reciprocal relationship between communication and collaboration, where strong existing communication networks facilitated collaboration and the process of collaboration helped to strengthen professional communication networks (van der Ham et al., 2013).

4.2.1. Adapting the intervention to the local context

There were two subthemes relating to 'accommodating cultural differences' and 'establishing where the intervention fits in'. Participants spoke about how the intervention had to be adapted to different cultural contexts, particularly between the US, where MST-CAN was developed, and the UK. There were also local adaptations to the intervention, where MST-CAN was considered in relation to the local organisational structures. The participants reflected on their experience of understanding how the MST-CAN intervention would fit into these systems. The adaptations to the intervention were necessary before collaboration between social work and MST-CAN practitioners could begin and in some ways hindered the process of collaboration. However, adapting the intervention to the local context helped to provide a foundation for future collaboration. In addition to this, the MST-CAN and social work practitioners were able to begin working together through the process of understanding where the service fits in as this required communication between both parts of the collaborative and with other agencies.

4.2.2. Committing to the intervention

This theme has four subthemes relating to 'shared professional values', 'leadership', 'availability of the intervention' and 'sustainability of the intervention'. Participants described their experience of factors that impacted on their commitment to working together to deliver the MST-CAN intervention. There was evidence that sharing professional values with the intervention helped social work and MST-CAN practitioners to commit to delivering the intervention. Seeing positive results from the intervention helped to reinforce the participant's belief in these values. In particular, in the case of MST-CAN, the restorative, collaborative approach to the families that

the intervention promoted was particularly important. Participants spoke about how key facilitators, who were identified as leading the intervention, helped to encourage motivation towards the intervention and facilitate an environment that was amenable to change. These two factors helped to lay the foundations for future collaboration between MST-CAN and social work practitioners and to improve awareness of the intervention.

Social work practitioners have strong professional values and had worked alongside services similar to MST-CAN in the past, which had been unsuccessful and temporary. Concerns about low availability of MST-CAN and the potential unfairness of the service being offered to only a few families, meant that some social work practitioners were initially reluctant to work with MST-CAN practitioners to deliver the intervention, which hindered the process of collaboration. Similarly, both social work and MST-CAN practitioners were concerned that the MST-CAN intervention would be short-term and this made it difficult for them to commit to the intervention, also hindering collaboration. In order to overcome these potential barriers, MST-CAN practitioners had to demonstrate their long-term commitment to the service in order to facilitate a collaborative working relationship with the social work practitioners. How they did this was considered more in the next key theme.

4.2.3. Working together to deliver the intervention

This theme contained four subthemes relating to 'expectations of each other', 'supporting colleagues', 'developing trust' and 'learning from each other'. Once the intervention was adapted to the local context and social work and MST-CAN practitioners had committed to the intervention, there were a number of factors important to overcome any perceived limitations and further facilitate collaboration.

Participants spoke about how managing expectations of the intervention helped social work and MST-CAN practitioners to develop a collaborative relationship. Participants also spoke about how developing trust was helpful in the collaborative relationship, particularly because the MST-CAN intervention required that the social work practitioner took on a different role and had less clinical responsibility than they usually would. MST-CAN practitioners had to overcome scepticism that social work practitioners had about the intervention. Trust was developed, in part, by building on existing relationships, sharing responsibility and openness in communication.

Social work practitioners often carry responsibility for the failings of the multi-professional team. This can result in increased anxiety about how to best support families, particularly when a child is at risk of abuse and neglect. It was important that MST-CAN practitioners were able to provide support to the social work practitioners in order to contain some of this distress. They were also able to support social work practitioners to alter some of the discourses around a family. The MST-CAN practitioners were able to help the collaborative relationship by using some of their clinical skills in their relationship with social work practitioners because they had smaller caseloads and more available time compared to the social work practitioners. Participants spoke about how they were able to learn some skills from the MST-CAN intervention through delivering the intervention with MST-CAN practitioners and this positive experience helped with the process of collaboration and meant that social work practitioners would be more willing to collaborate in the future and to describe the intervention favourably to their colleagues.

4.3. Factors that helped and hindered collaboration

The primary aim of the research was to determine what factors helped or hindered the process of collaboration. The clinical implications of these factors are considered in detail in part 4.7. Factors that *helped* collaboration were: opportunities to work together in adapting the intervention to the local context; shared professional values; leadership from key facilitators; managing expectations of the intervention; developing trust in the MST-CAN practitioners; supporting social work practitioners in their work; and learning from the intervention whilst working alongside each other. Factors that *hindered* collaboration were: delays experienced in adapting the intervention to the local context; concerns about lack of availability of the intervention; concerns about how sustainable the intervention was; challenges from the change of role experiences by social work practitioners; a lack of trust in the MST-CAN practitioners; and scepticism about how the intervention could help families.

4.4. Discussion of research findings

The themes presented in the results section were compared to the research focusing on introducing an EBI to existing services and those that focus more specifically on the process of collaboration. The existing research related to the following subthemes found in the current research project: ‘accommodating cultural differences’, ‘understanding where the intervention fits in’, ‘leadership’, ‘sustainability of the intervention’, ‘managing expectations’, ‘developing trust’ and ‘learning together’. There was no existing evidence from the literature for the following subthemes: ‘shared professional values’, ‘availability of the intervention’ and ‘supporting colleagues’. The reasons for this are unclear. It could be that because

the intervention is novel and has been implemented into a context that is not often explored: children's social care services in the UK, the experience of professionals who were interviewed is different than in previous research. The differences could also result from the method of data collection and analysis that was employed by the researcher in the current research project. These differences in research methodology are considered more in part 4.6. These findings of the current research project in comparison to existing research are considered in more detail below.

4.4.1. Adapting the intervention to the local context

The subtheme 'accomodating cultural differences' related to translating MST-CAN from the US to the UK context and within local social care teams. This occurred in the early stages of the intervention being introduced, when establishing collaboration is important for continued success (Wolff & Gillian, 1991). One of the key challenges of adapting MST-CAN in this way, was the lack guidance and time available to consider these adaptations in advance of the intervention being introduced. This finding builds on previous research that has shown that a lack of guidance and planning when introducing a new intervention can lead to unsuccessful collaboration (Miller & Ahmad, 2000). However, in relation to the introduction of MST-CAN, a lack of guidance and time to plan the intervention did not necessarily lead to unsuccessful collaboration, although it did delay the process of collaboration. Once the model had been adapted to the local context, collaboration could be facilitated.

The subtheme 'establishing where the intervention fits in' involved considering how MST-CAN would fit into the existing service structure, which involved making links between different services to avoid duplication and improve

communication. A key part of making links is in accommodating the needs of other agencies whilst continuing to meet the requirements for the intervention. This was a challenge for the MST-CAN and social work practitioners and adds to previous research where, Macdonald et al. (2004) found that there were difficulties in ensuring links between different parts of a service when introducing the Primary Mental Health Worker (PMHW) role into Child Adolescent Menteal Health Services (CAMHS), in the UK. Similarly, Akin et al. (2014) found that balancing the needs of multiple professionals in social care can make collaboration between professionals challenging. The MST-CAN practitioners were able to overcome these potential limitations by taking a lead in communicating with and co-ordinating other services and as in previous research, this strengthening of communication networks led to improved service delivery (Anderson-Butcher, Lawson and Barkdull, 2002). This is not always a priority when an intervention is introduced into a service and previous research has found that finding time to have conversations in order to develop links was difficult when introducing new services (Tinati et al., 2012). Although the MST-CAN team was small in size, they were able to have these conversations in order to lay the foundations for collaboration with social work practitioners and other agencies.

4.4.2. Committing to the intervention

In relation to 'shared professional values', it was clear from the interview data that social workers have strong values relating to their professional role. Some participants reported that they saw the MST-CAN intervention as sharing a number of their values, which made them more willing to collaborate to deliver the intervention. This idea of matching professional values to an intervention was not evident in the

other literature. However, previous research has identified that professionals can potentially experience confusion and discomfort when working collaboratively (Clark, 2000; Forgatch & Patterson, 2010). It could be that sharing professional values with the intervention is one factor that helps to reduce this confusion and discomfort when the intervention is introduced.

The interview data showed that 'leadership' was important in inspiring and motivating MST-CAN and social work practitioners who were delivering the intervention. Key facilitators were identified as important and it was also found that positive experiences of the intervention led to an increased willingness to share information between social work practitioners. Previous research has also identified the importance of peer support when introducing an EBI (Akin et al., 2014). Effective leadership helped to create an environment in which change can occur as the intervention is introduced. Grol & Grimshaw (2003) also found that an environment conducive to progressive change is important for supporting collaboration. Other research has also shown that it is difficult to create such environments in the inherently complex setting of child social care and effective leadership with key facilitators helps to facilitate such change (Chaffin & Friedrich, 2004; Palinkas et al., 2011). It was unclear what the leaders of MST-CAN did to overcome these barriers to leadership in this context. Previous research suggested that when leaders were knowledgeable about an intervention, this led to a greater understanding and acceptance (McCrae et al., 2014; Haight et al., 2014). This could have been part of what helped the leaders who were introducing MST-CAN to facilitate successful collaboration between MST-CAN and social work practitioners. Consistent leadership was identified as important in other research and this was not identified in the current

research study. This may have been because the intervention was still relatively new (Frambach & Schillewaert, 2002).

In relation to 'availability of the intervention', social work practitioners believe in fairness in the delivery of services. The lack of availability led to a sense of unfairness and uncertainty about the intervention because MST-CAN was only available to nine families across Leeds, at any one time. In addition to this, a number of social work practitioners were unsure how the decision to accept or reject a referral was made. This led to a subsequent sense of powerlessness and unpredictability in relation to the referral process for MST-CAN. This issue of availability was not identified in previous research. However, previous research has found that staff empowerment is important and can help to avoid uncertainty in the collaborative relationship (Forgatch & Patterson, 2010). Despite the confusion and sense of unfairness, the participants who were interviewed had a referral accepted, which may have mitigated any sense of powerlessness. This experience could have been different for professionals who did not have a referral accepted. It may be that those who did not have a referral accepted would be less likely to commit to the intervention because of this.

Concerns about 'sustainability of the intervention' meant that social work practitioners were unsure if the intervention would be around for a long time or be discontinued as the other interventions had. The MST-CAN practitioners were also unsure if the intervention was offering anything different and therefore worth investing in. Previous research has identified this as a problem in introducing EBIs because there are a large number of new publications available each day which can make it challenging to keep track of new EBIs and to determine which interventions are worth while (Coppus et al., 2007; Sackett et al., 1996; Berliner, 2002). If

professionals believe that the introduction of an EBI is necessary and beneficial, it is more likely to be implemented successfully (Bouckenooghe, 2010). As a result, MST-CAN was at risk of being seen as an idea that would not be worth investing in. In order to overcome these perceptions, and for the service to be seen as a worthwhile investment, the MST-CAN practitioners had to demonstrate their commitment to the social work practitioners, whilst managing their own uncertainty. This was made possible through managing expectations, trust, supporting each other and learning together, which are considered below in relation to previous research.

4.4.3. Working together to deliver the intervention

The process of working together to deliver the MST-CAN intervention helped to overcome some of the reservations that social work practitioners described; 'managing expectations of the intervention' was an important component of this. MST-CAN practitioners were able to manage social work practitioners expectations to ensure that they knew what to expect from the intervention and from their change in role (when delivering the MST-CAN intervention, child protection concerns are responded to by the social work practitioners and the MST-CAN practitioner becomes the clinical lead). The MST-CAN practitioners were able to help to manage the social work practitioner's expectations by sharing information and facilitating open discussion. Previous research exploring collaboration between MST-CAN and social care in Australia found that expectations and perceptions of the intervention changed as the social work practitioners began to learn more about MST-CAN and that sharing information was an important part of managing expectations which helped to form the foundation for collaboration (Herbert et al., 2014). It is unsurprising that this result was mirrored in the present study as the intervention and professional groups are very

similar.

'Developing trust' is essential if professionals are going to work together to deliver an intervention. As described above, social work practitioners had to allow the MST-CAN practitioners to take the lead role in providing support to a family when a child is at risk of further abuse or neglect. In addition to this, the MST-CAN intervention was often successful in facilitating change within a family when other interventions had been unsuccessful. This resulted in a change in roles for the social work practitioner and a sense of scepticism about the intervention. As a result, sharing decisions, sharing responsibility and open communication were an important part of developing a trusting relationship. The importance of shared decision-making and agreeing joint accountability have been identified as important in the process of collaboration previously (Clark, 2011). It has been suggested that the process of shared decision-making can create a sense of inter-dependency and empowerment of staff (Sullivan, 1998; Evans, 1994; Cowan & Tivet, 1994). These findings were not replicated in the current research, although the researcher did not explore their sense of empowerment with participants. Some MST-CAN practitioners spoke about how they were able to develop their existing relationships to develop trust with social work practitioners. This ideas of nurturing existing relationships between professionals has been identified as important in facilitating collaboration in previous research (Haight et al., 2014).

As discussed in chapter one, social work practitioners often have unmanageable caseloads and hold responsibility for failings of the multi-professional team (Burke, 2013). As a result, it was important that MST-CAN practitioners were 'supporting colleagues' to manage their anxiety which was primarily associated with the intensity of their role. The MST-CAN practitioners were able to do this by

developing a collaborative, empathic relationship with the social work practitioners in a way similar to how they would with a family accessing the service. MST-CAN practitioners were in a favourable position to support their colleagues because they have specialist training, small caseloads and more available time. This finding was not evident in previous research, possibly because often only one half of the collaborative are interviewed.

Asthana (2002) suggested that collaboration often involves mutual sharing of knowledge, principles and understanding. Learning together and working together can be an inseparable process and can help to strengthen the development of collaboration if the experience is positive. There were examples of when the social work practitioners were able to learn from the MST-CAN practitioners and this strengthened their collaborative relationship. In particular, the social work practitioners were able to apply ideas taken from delivering the MST-CAN intervention, such as structure, clarity, consistency, empathy and creativity to their work. This led to more favourable discussions with social work colleagues, helping to facilitate a positive narrative of MST-CAN in the social work team. Development of shared knowledge was identified as important van der Ham et al (2013) when exploring collaboration between child mental health, adult mental health and community child services. In the current research, there was a sense that more recently qualified social workers may have been more receptive to the process of learning which, was not considered in previous research.

4.5. Models of collaboration

As mentioned in chapter one, the literature review did not reveal any models of inter-professional collaboration that have been developed in the context of

children's health and social care. There were five potential models of collaboration that were identified and the researcher chose to focus on two models of collaboration that were devloped in the context of gerentology research andy adult health care, respectively. These models were chosen as they provide opportunity to consider the applicability of models of collaboration developed in two different contexts to the current research project. The two models to be considered are the 'five stage model of professional collaboration' and the 'structuration model of inter-professional collaboration'.

4.5.1. Five-stage model of collaboration

Gitline, Lyons and Kolodner (1994) used social exchange theory in combination with existing literature on the development of teams, to inform their understanding of inter-professional collaboration in the context of gerontology research in the US. The key concept in social exchange theory is that we can better understand social structures through understanding social interactions that occur between groups. The two components of the model relate to exchange and negotiation, where exchange is based on the idea that a person will only join a group that benefits them and will work to help the group to achieve its objectives. The process of negotiation is based around determining what the person will offer to the group and what benefits they expect to receive.

The model was developed to facilitate collaborative research and educational teams in the context of gerontology. The five stage model expanded on social exchange theory to encompass the following themes: 'assessment and goal setting', which involved establishing goals and assessing if a collaborative relationship was needed; 'determination of a collaborative fit', which related to exchange and

negotiation of roles and ideas to establish trust in their relationship; 'identification of resources and reflection', which is about returning to the group to determine what resources will facilitate collaboration and what potential benefits might be; 'refinement and implementation', which involves considering ideas that are presented and what each professional may contribute; and 'evaluation and feedback', where progress and roles are analysed and future aims are developed.

Although the model was developed in a different context, there are some similarities with the findings of the current research project. The need for 'goal setting' was not described in the current research project as there was a pre-determined goal for the MST-CAN intervention: to support the family to make changes in order to reduce the likelihood of future abuse and neglect for the child. However, the idea of 'determination of collaborative fit' was relevant to the current research project. In particular, the social work and MST-CAN practitioners spoke about the importance of 'shared professional value', 'managing expectations' and 'developing trust', which were all part of the process of understanding how they might be able to work together to deliver the intervention. The concept of 'identification of resources' from the five stage model could be applied to the themes of 'availability of the intervention' and 'sustainability of the intervention' as participants spoke about concerns that resources were not plentiful and going to last at this stage in the process of collaboration.

The concept of 'refinement and implementation' was not relevant to the process of collaboration in the current research project because there was not much opportunity for new ideas to be introduced into the MST-CAN intervention as it followed a set format. The concept of 'evaluation and feedback' was also not relevant to the current research. Participants did not reflect on how their experience of the

process of collaboration could be considered so that future goals could be set. It may be that the current research project helped to facilitate this process of evaluation for the participants as it allowed time to reflect on the experience of working together and to consider how collaboration may be facilitated differently in the future.

Two of the five stages were relevant to the current research project: 'determination of collaborative fit' and 'identification of resources'. The lack of similarities between the five stage model and the current research findings are likely due to a number of factors. The five stage model was theoretically grounded but was not validated in further research. In addition to this, the five stage model was developed in consideration of collaboration in the context of research for older adults in the US. This context is different from the UK context of children's social care in relation to structure, aims and resources. Also, collaboration in the context of research provides opportunity for different professionals to determine their role and the goals of the implementation method. When an EBI is introduced, there is a set requirement for the practitioners who are facilitating it and the goals are pre-determined. However, it could be that this model is developed further to consider how research in the context of children's social care could be facilitated collaboratively. There is limited evidence based research in this area and it could be that taking some of the ideas from social exchange theory and the five stage model could provide a foundation for a model of collaborative research in children's social care.

4.5.2. Structuration Model of Inter-Professional Collaboration

Structuration is an idea based on the analysis and understanding of structure and agency in the development of social systems. The structuration model of inter-

professional and inter-organisational collaboration has been validated in teams, between organisations and across health care networks, through semi-structured interviews and analysis of written material (D'Amour, Sicotte & Lévy,1999; D'Amour, 2004; D'Amour et al., 2008). The model focuses on the relationship between individuals, the interaction between group relationships and between individuals and the organisation (D'Amour et al., 2008). The model has four key components; two of which relate to the relationships between professionals who are collaborating and two relate to the organisation of collaboration. The first component is 'shared goals and vision', which relates to common goals, differing motives, allegiances and expectations of collaboration. The second component is 'internalisation', which relates to the professional's awareness and management of interdependency, knowledge of the other professional group's values, and trust. The third component is 'formalisation' and relates to how procedures that communicate desired outputs exist and how information about outcomes is communicated. The fourth component is 'governance', which relates to organisational leadership in support of collaboration and innovation. These components have been divided into ten key sub-components.

There are a number of similarities between the current research and the components that were identified in the structuration model. The concept of 'shared goals and vision' is related to the themes 'understanding where the intervention fits in', 'shared professional values' and 'managing expectations' which were all part of the process by which MST-CAN and social work practitioners developing a shared understanding of how they would work together. However, there was no explicit discussion about the importance of shared goals as identified by the structuration model. D'Amour, Sicotte and Lévy (1999) suggest that the process of

‘internalisation’, when professionals manage their interdependency, is important and this was evident in the current research as MST-CAN practitioners spoke about the process of ‘supporting colleagues’ to deliver the intervention. However, this support was not reciprocated, as in the structuration model, so could not be described as a process of interdependence in the way that D'Amour, Sicotte and Lévy (1999) proposed. As part of an interdependent relationship, ‘developing trust’ with the other professional group is an important part of ‘internalisation’ component of the structuration model was important in the current research project. Although there was little evidence of a reciprocal supportive relationship, trust was also described as important for the participants in the current research.

‘Formalisation’ is an important component of collaboration for D'Amour, Sicotte and Lévy (1999) and related to how desired outcomes are communicated in the collaborative relationship. This aspect of the model was less relevant to the participants in the current research. The sharing of information was however important and could have involved communication about desired outcomes but the interviewer did not ask about this directly. The fourth component of the structuration model is ‘governance’, relating to leadership and support for collaboration and innovation. This was identified as important to participants in the current research, in particular, participants spoke about the importance of ‘leadership’ and the role of leaders in creating an environment conducive to collaboration and change.

In summary, some aspects of the structuration model of inter-professional collaboration were also identified by the participants in the current research project. In particular, ‘shared professional values’, ‘managing expectations’, ‘supporting colleagues’, ‘developing trust, ‘sharing of information’ and ‘leadership’. However, there were aspects of inter-professional collaboration that were identified as important

in the current research that were not described in the structuration model: 'accommodating cultural differences', concerns about 'sustainability of the intervention', 'sustainability of the intervention' and the importance of 'learning from each other'. It could be that because the structuration model was developed in the context of health care in Canada, which is a different context to the current research and could have implications for what professional identify as important in the process of collaboration. It may be that the factors of the model could be considered in conjunction with the findings of the current research in order to consider future inter-professional collaboration. If the model was to be used in future research, it may be possible to adapt it to the context of children's health and social care by adding the four components from the current research project that the model did not account for: 'sustainability of the intervention', 'sustainability of the intervention' and the importance of 'learning from each other'. However, it may be possible to develop a model of inter-professional collaboration that includes findings from the current research project and research prevented in the literature review.

In conclusion, both the five stage and structuration models of collaboration shared similarities with the finding of the current research project and the structuration model was the best fit of the two. Consideration of models of collaboration developed in other contexts could help to develop a formal structure to facilitate collaboration in the future. The opportunities to develop models of collaboration are considered in more detail in part 4.8.

4.6. Evaluation of method: strengths and limitations

The research has confirmed some of the findings from previous research and has offered a new perspective on collaboration in the context of children's social care.

There are a number of strengths, weaknesses and areas for development in the research which are considered below.

4.6.1. Strengths

The limited amount of existing literature focusing on collaboration in child health and social care has focused on the *outcomes* rather than *process* of collaboration. Research focusing on outcomes makes it difficult to establish how successful collaboration could be facilitated in the future because it does not help us to understand what led to the successful collaboration. In addition, it is difficult to identify if the reported benefits of collaboration were present before the EBI was introduced. Herbert et al. (2014) found that social workers reported working in a way similar to that of the MST-CAN approach before the collaboration. In the current research, the focus was on the process of collaboration, which will enable some of the results to be useful for professionals involved in implementing new EBIs, like MST-CAN, into existing services.

The method of data collection and analysis used in this research allowed for an in-depth understanding of the process of collaboration between MST-CAN and social work practitioners. Previous research used self-rated measures which limits the amount of detail that can be explored in relation to the participant's experience (i.e. Coleman et al., 2008). In some studies, exploring the professional experience of collaboration, participants were asked leading questions which were based on the idea that collaboration was successful. This may have impacted on the type of responses that participants were willing to give. For example, Anderson-Butcher, Lawson and Barkdull (2002) asked participants 'what do you believe have been the major accomplishments of the design team?' Anderson-Butcher, Lawson and Barkdull

(2002) and Van der Ham et al (2013) both asked closed questions that did not allow for exploration of ideas and may limit the depth of the information obtained. The present research was able to address these limitations by asking questions that were open and did not lead participants i.e. 'What is your experience of working with Children's Social Services/MST-CAN?' In addition, the topic guide was used to ensure similar questions were asked but participants were given opportunity to expand on their responses in all questions.

In order to understand the process of collaboration in more detail it is important that all key stakeholders are allowed to provide their perspective. In particular, this should include representatives from both parts of the collaborative relationship. Most of the studies considering the professionals experience of inter-professional collaboration explored the view of only one group of professional groups. For example, Herbert et al. (2014) only considered the outcome of collaboration from the perspective of one half of the collaborative relationship. In addition, they did not ask for the experience of MST-CAN practitioners there were a low number of participants with only five people taking part (Herbert et al., 2014). In the present research, the data was collected until saturation was reached and no new codes were being generated from the interview data. This meant that 11 participants were interviewed, in total. Other considerations, such as cultural barriers, were not necessary in the current research but have been a factor in other research. In Clark's (2011) study for example, participants were interviewed in a language that was not their mother tongue.

4.6.2. Limitations

In the research by Haight et al. (2014), the participants were involved in the implementation of the intervention and were likely to have wanted to portray a positive picture of the collaboration. The current research interviewed participants who were invested in the success of the collaboration, in particular the MST-CAN supervisor and MST manager. However, to some extent all of the MST-CAN professionals were required to manage the perceptions of the intervention, which may have impacted on their responses. However, the research method was chosen so that anonymity, confidentiality and the focus on the process of collaboration should have enabled participants to answer with less concern about the implications of their responses.

The process of implementing an EBI is complex and changes as the intervention becomes more established. The same process of change is also present in a collaborative relationship. When the interviews took place, the service had been implemented for less than 18-months, which means that a maximum of two, nine-month cycles had been completed. It may be that the experience of collaboration would have been different if they were completed within the first MST-CAN cycle and when the participants were actively collaborating. This inevitable difficulty was a limitation in other research, i.e. Palinkas et al. (2011) carried out their investigation during the initial stages of the EBI implementation and the participant's experience may have been different from those in later stages of collaboration.

In the Herbert et al. (2014) study, the MST-CAN team member conducted the interviews, which is likely to have impacted on the quality of responses and may have resulted in bias from the respondents. In the current research, the researcher was introduced to the participants as from the University of Leeds. However, it may have

been that the participants perceived the researcher to be 'working for' the MST-CAN team. This could be because the social work practitioners would perceive the MST-CAN team to be most interested in understanding the intervention. In addition, MST-CAN is associated with practice based research. One participant reflected on his experience of working with MST-CAN, which illustrates this point.

> *'You do feel, a bit, like you're part of a big research project'*
>
> *(Michael, Social Work)*

In addition to this, the researcher initially contacted the MST-CAN team to consider how the research may be facilitated, rather than the social work team. This may be that this was communicated informally between team members who were due to be interviewed in the research. The perception of bias is difficult to overcome and it was hoped that anonymity and confidentiality enabled some participants to feel comfortable to respond with their true opinions, without feeling that the researcher desired a specific response.

A further limitation of the current research is that the sample included participants who had a referral accepted by MST-CAN. The experience of these participants is likely to be different to those of social work practitioners that did not have a referral accepted. However, the collaboration between MST-CAN and social work practitioners only took place after the referral was accepted. As a result, the experience of a social work practitioner who did not have a referral accepted could have enabled a more detailed understanding of the early stages of collaboration i.e. gaining information about the service, making a referral, etc. There may also be a group of social work practitioners that would not refer to MST-CAN because they

have a negative perception of the intervention. The sample was collected over a short time frame of three weeks. It is likely that allowing more time to reflect, evaluate and develop the key themes would have enabled further questioning about some of the subthemes, enabling the researcher to have a better understanding of what practitioners did to overcome problems and how they facilitated collaboration through leadership, etc. If this was the case, clearer recommendations could have been made with tangible examples of how to achieve them.

Opportunity to address the limitations in the current study would have been preferable but was not possible because of a lack of time and resources. The 'directions for future research', considered below, gives consideration to how further investigation could potentially add to the findings of the current research and to continue to develop the understanding of the process of collaboration, particularly in the complex context of children's social care.

4.7. Implications and recommendations

One other study has focused on the outcome of collaboration between MST-CAN and existing professionals but the research was based in a different cultural and organisational context, had limited numbers of participants and focused on only one half of the collaborative relationship (Herbert et al., 2014). As a result, there are a number of key recommendations from the research which are important for professionals working with and introducing MST-CAN or other EBIs in the context of children's health and social care.

4.7.1. Clinical implications

The primary clinical implications relate to which factors that help and hinder collaboration can be considered by professionals who are introducing new EBIs into existing services. These implications are particularly relevant if the professional is attempting to facilitate collaboration as part of this process. As discussed above**,** there were a number of factors from the subthemes that helped to facilitate the process of collaboration between MST-CAN and social work practitioners. One factor that helped collaboration was opportunities to work together. It may be that providing opportunities for professional groups to work alongside each other in developing the intervention could enable the development of a collaborative relationship. If this happens earlier in the relationship, then collaboration is likely to be more successful. Another factor that facilitated collaboration was shared professional values. Professional are more likely to commit to an intervention if they believe that it embodies some of their values. For professionals introducing new EBIs it is important to ensure that the values that underpin the intervention are communicated clearly to professionals who are carrying out the intervention. This could be carried out in the form of an interactive session, where professionals identify their own values and how they do or do not match those of the intervention.

Leadership from key facilitators was another factor that helped the process of collaboration. Identifying key facilitators who can promote the intervention and disseminate information in a way that is motivating and can help facilitate organisational change is important when introducing a new intervention. In addition, encouraging professionals who are collaborating to be vocal about their experience and to disseminate this information to their colleagues is important. This process can help to empower these professionals to become leaders of the intervention within their

local team. This is particularly important in large, complex teams such as children's social care. Managing expectations of the intervention is important in ensuring that professionals who are collaborating are aware of their role and what to expect from the other team members and from the intervention. This can occur through the process of collaboration and could be facilitated formally in an introductory session.

Another factor that helped MST-CAN and social work practitioners to collaborate was developing trust. Given that the new intervention is unknown and potentially involves a change in role for the professionals involved, it is important that they are able to trust each other. Trust can develop naturally through the collaborative process and could be facilitated by giving the professionals opportunity to spend time with each other and understand the other professional's role and the intervention in more detail. Given the demands on social work practitioners, support from MST-CAN practitioners was helpful in developing their collaborative relationship. When introducing a new intervention, it may be important to consider if one professional group may have less support within their role and if there is a difference in workloads. Awareness of this could help professionals to facilitate collaboration by establishing a more formal support structure. Learning from the intervention and the other professional group helped social work practitioners to collaborate with MST-CAN practitioners. Professionals who are introducing new services could facilitate more formal opportunities for the professional groups who are required to collaborate to learn from each other. This learning experience would help the professionals to develop new skills and to begin to understand how the intervention works in practice.

One factor that hindered collaboration was the delays that were experienced in adapting the intervention to the local context. The changes in adapting MST-CAN to the UK context were not anticipated in advance and this meant that collaboration

could not begin immediately. When possible, professionals introducing interventions to new contexts should attempt to plan for any potential changes to be made and consider what implications these changes might have for the professionals who are required to collaborate. Two other factors that hindered collaboration was concerns that social work practitioners had about the lack of availability and sustainability of the intervention. These concerns were unavoidable to some extent as they were based on the previous negative experiences that the social work practitioners had when previous interventions were introduced. In addition, funding for the intervention meant that only nine families could receive the intervention at any one time and the MST-CAN intervention was a pilot and funded for a limited amount of time. Openness and honesty about the process of referral for the intervention is important so that the professional groups do not feel that the process is unpredictable and they are powerless to influence it. In addition, it is important to communicate to professionals that are collaborating why the EBI is different from other interventions that they may have come into contact with, and ultimately worth investing in.

Introducing an EBI may result in a change of role for professionals who are required to collaborate. The changes can be difficult to manage and lead to confusion and difficulty collaborating to deliver the intervention. It is important to support professionals to understand how the intervention might impact on their role and how they can maintain their professional identity whilst delivering the intervention. With this change of role and because the intervention was delivered at a time when a family is in crisis and social work were unable to facilitate a change, there was a lack of trust in the MST-CAN practitioners. Trust when collaborating is important and can be developed through sharing decisions, sharing responsibility and open communication between the professional groups. This approach to working together should be

encouraged by any professionals that are introducing a new intervention that requires collaboration. Within health and social care settings, professionals may already know each other and nurturing these professional relationships can help to develop trust and facilitate the collaborative relationship.

4.7.2. Recommendations from participants

Some of the participants made specific recommendations about how collaboration could be improved in the context of the MST-CAN intervention. One participant proposed that multiple two-hour sessions could be facilitated by MST-CAN practitioners to all of the teams in Leeds Children's Social Work Services. They suggested that this would have enabled consistent provision of information and would help with collaboration because the information would be provided from the MST-CAN practitioners and any questions about the service could be answered directly. Another participant suggested that professionals introducing the intervention should give up front information about the potential benefits of collaboration to those who will deliver the intervention. This related to the above recommendation about open communication and being clear about what the intervention will offer to the service and the practitioner. One participant also spoke about how, in relation to leadership, there was an important role for people who were "champions" of practice and were able to help their colleagues manage expectations of the service through describing their experiences. The participants interviewed spoke about how they valued the experience of shared learning which, generally, was not something that they had anticipated and two participants recommended that this should be encouraged more regularly.

4.7.3. Facilitating inter-professional collaboration: 10 things to consider

In summary of the above points, there are 10 key points which could be considered by professionals who are introducing an EBI that requires professionals to collaborate.

1. Consider what adaptations might have to be made to the intervention for it to fit within the cultural and organisational context.
2. Establish a forum in which the EBI can be introduced to different parts of the service by key facilitators.
3. Introduce the intervention to professionals, highlighting the key values that it promotes and how they could match their own values.
4. Explain how the EBI that you are introducing is different to others that have been introduced before. You need to demonstrate that this intervention is worth investing in.
5. Establish who will be able to lead the intervention across the service and who will be best places to disseminate the information in individual teams.
6. Enable processionals to work together as soon as possible as this increases the likelihood of successful collaboration.
7. Ensure that professionals are aware of their role and what to expect from the other professional group.
8. Be open about the referral criteria and the likelihood of further funding for the intervention.
9. Trust can be facilitated by an open, collaborative relationship. This should be demonstrated and encouraged as the intervention is introduced. It could be encouraged further through providing opportunity for professionals to spend more time together.

10. Establish opportunities for the professional groups to learn about each other's roles and what skills they bring to the intervention.

4.8. Directions for future research

The focus of the current research project was on the process of collaboration and most previous research has focused on either the process *or* outcome. A possible direction for future research may be in attempting to understand both the process and outcome of collaboration, simultaneously. This could be done by exploring participants' experience of working together (as in the current study) as well as their views about the success of the collaboration. In addition, professionals involved in facilitating the intervention and families could be asked if they feel the collaboration was successful. An objective paper-based measure could be used to establish if team working skills/collaboration improved after the intervention. This would help to provide guidance for professionals who are wanting to consider how best to implement an intervention whilst, at the same time, informing them of what the outcomes of the process might be. It would also help to draw comparisons between different processes of collaboration and their relative influence on the outcome.

There are a number of theoretical ideas that have been proposed as a result of the current research project. Future research could attempt to test these ideas empirically to establish if they have validity in the context of MST-CAN. The MST-CAN intervention has recently been implemented in Newcastle and at the time of writing is due to be introduced in Leicester and Nottingham. This provides a unique opportunity to validate the findings from the current research project and our understanding of how professionals work together to deliver this intervention. Future

research could also attempt to establish if these findings have validity in a different context. One way to do this would be to apply the 10 things to consider when implementing a new EBI that required professionals to collaborate, to help determine if these steps lead enhance the process of collaboration and lead to successful collaboration between professional groups.

A number of findings in the current research project were found in other literature focusing on introducing EBIs and collaboration and a number of findings were not. There is no available model of collaboration for children's health and social care. A potential direction for future research is to combine these findings and develop a universal model that can be applied across various settings in which an EBI would be introduced into children's services. These services are different from adult services because they typically provide support for the entire family rather than just an individual.

When adapting an intervention between contexts it is important to ensure fidelity to the model. In the current research project there was no objective evidence to establish if these adaptation resulted in fidelity to the model. This could be explored in further research in relation to the adaptation of MST-CAN or another EBI across cultural contexts. This type of research could take two forms: establishing if model fidelity was maintained and/or exploring the challenges of adapting a model and maintaining fidelity in an attempt to understand what factors must remain the same. This would be useful because the premise of EBIs could be lost if the model is no longer valid because of the cultural adaptations that are made.

The current research project considered only one component of introducing an EBI: collaboration between professionals. Other key components include planning the EBI, staff training and adapting to feedback. There was little evidence that these

processes had been explored in detail in the context of children's health and social care. It may be useful to consider these components of introducing an EBI in the context of MST-CAN in order to establish which components are key to introducing this intervention. It could also be that researchers attempt to develop a model of introducing an EBI into children's social care. There is no model currently available and this could help to further promote an evidence based approach to service delivery in this context.

4.9. Summary and conclusions

The current research aimed to add to the existing literature about collaboration when a new EBI is introduced. The researcher explored the experiences of collaboration between social work and MST-CAN practitioners who were working together to deliver the MST-CAN intervention to families in Leeds Children's Social Work Services. The aim of the research was to determine which factors helped and hindered the process of collaboration in this context. The analysis of 11 semi-structured interviews with social work and MST-CAN practitioners revealed three key themes that described the process of collaboration: 'adapting the intervention to the local context', 'committing to the intervention' and 'working together to deliver the intervention'. These themes consisted of ten sub-themes which described a number of factors that helped and hindered the process of collaboration for social work and MST-CAN practitioners.

The findings of the research mirrored and built on the existing literature and provided new understanding about what facilitates collaboration in the delivery of MST-CAN in children's social care. These findings have a number of potential clinical implications for professionals involved in introducing an EBI into other areas

of children's health and social care, particularly when the emphasis is on collaboration. Ten key points for introducing an EBI have been presented as a summary of how these findings could be applied in other contexts. In addition, there are a number of implications for future research both within the context of the MST-CAN intervention and for the introduction of other EBIs. Further research in this area would help to develop our understanding of how to introduce an EBI and further promote an evidence based approach in the context of children's social care. The findings of the current research project may be useful for any professional who is involved in introducing an EBI and those who are collaborating alongside other professionals to facilitate the intervention.

4.10. Personal reflections

I was surprised to discover that only a small amount of research takes place in the context of children's social care and that there is no formal procedure for ethical approval. However, this did fit with my previous experience of social care as under-resourced and under-valued. I found the process of interviewing the social work and MST-CAN practitioners rewarding and was grateful to have an opportunity to have their views heard. I hope that this project will be useful for the MST-CAN service and for children's social care services in understanding how to facilitate collaboration now and in the future. I also hope that other professionals involved in introducing new EBIs will find some of this information helpful. I am grateful to work in a profession (clinical psychology) where EBIs are routine in clinical practice and hope that this project can become a useful part of the evidence base for collaboration in children's social care.

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APPENDICES

Appendix 1: Medline search strategy and Prisma flow chart

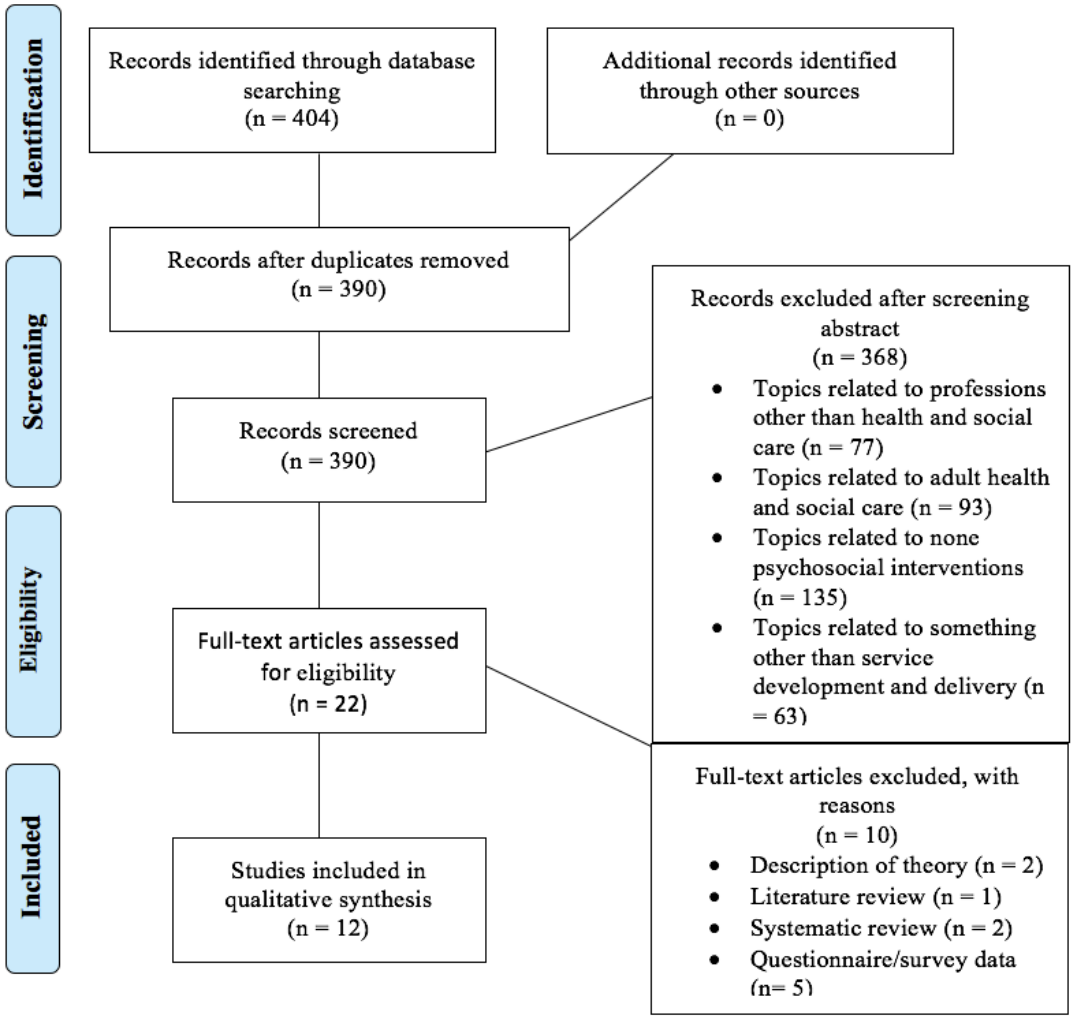
1.1. Medline search strategy

1	(child adj3 "social work*").mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
2	(child adj3 "social care").mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
3	(child adj3 "health profession*").mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
4	Social Work/
5	Child Health Services/
6	Child Welfare/
7	Child Guidance Clinics/
8	(adolescent adj3 "social work*").mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
9	(adolescent adj3 "social care").mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
10	(adolescent adj3 "health profession*").mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
11	**or/1-10 [Child Health and Social Care Professionals]**
12	change.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
13	Organizational Innovation/
14	Health Care Reform/
15	Diffusion of Innovation/
16	"Diffusion of Innovation".mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
17	Program Development/
18	Innovation.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
19	Reform.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
20	Development.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
21	**or/12-20 [Change]**
22	Delivery of Health Care/
23	Family Therapy/
24	Health Plan Implementation/

25	Evidence Based Practice/
26	Psychotherapy/
27	service delivery.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
28	service implement*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
29	((healthcare or health care) adj delivery).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
30	(family adj3 therapy).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
31	implementation.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
32	((evidence based or evidence-based) adj practice).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
33	(psychotherapy or psychological therapy).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
34	**or/22-33 [service delivery]**
35	"Attitude of Health Personnel".mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
36	attitude*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
37	behavio?r.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
38	belief*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
39	cognitive dissonance.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
40	cognitive change.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
41	identity.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
42	social identity.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
43	**or/35-42 [attitudes and beliefs]**
44	Interdisciplinary Communication/
45	Interprofessional Relations/
46	Cooperative Behavior/

47	Interinstitutional Relations/
48	Multidisciplinary Communication/
49	Communicat*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
50	Cooperat*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
51	Teamwork*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
52	**or/44-51 [communication]**
53	**11 and 21 and 34 and 43 and 52**

1.2. Prisma flow chart



Appendix 2: Topic guide versions 1 and 2

2.1. Topic guide version 1

Thank you for agreeing to take part. As you've read on the information sheet, previous research shows that collaboration is an important part of introducing interventions like MST-CAN. We want to explore the experience of staff in Leeds Social Services and the MST-CAN team to better understand their experience of collaboration. I'll ask a few basic questions and then some more specific questions about your experiences of working with Children's Social Services/MST-CAN. Do you have any questions before we start?

- What is your job role?
- Where are you based?
- How long have you been qualified for?
- Have you worked with MST-CAN before?

1. What factors helped and hindered the introduction of MST-CAN in Children's Social services?

Prompts:

What made the introductory stages easier?

What made the introductory stages difficult?

Could this have been done differently? If so, how?

2. What is your experience of working with Children's Social Services/MST-CAN?

Prompts:

Are there any advantages about working with Children's Social Services/MST-CAN?

Are there any disadvantages about working with Children's Social Services/MST-CAN?

Has working with Children's Social Services/MST-CAN impacted on how you work?

3. What is your experience of communication with Children's Social Services/MST-CAN?

Prompts:

With each other?

With the team?

Has this changed over time?

How did you first hear about MST-CAN?

Are there any differences in what is important to communicate to different parts of the service?

Has this changed over time?

Is there anything that would help this communication?

4. Who led the introduction of MST-CAN in Children's Social Services you're your perspective?

Prompts:

Did this person/these people have enough knowledge and understanding of the process?

What did they do?

How did that impact on the way that you work?

Could it have been done differently?

If so, how?

In what way have they facilitated the introduction of MST-CAN?

5. How have attitudes and behaviours changed whilst working together?

Prompts:

Have you been able to maintain your professional identity whilst working with the Children's Social Services/MST-CAN?

What has helped you to maintain your professional identity?

Have your views of Children's Social Services/MST-CAN changed since your first began working together?

Have you enjoyed working alongside chidlren's services?

Is there anything else you would like to add?

Version 1

2.2. Topic guide version 2

Thank you for agreeing to take part. As you've read on the information sheet, previous research shows that collaboration is an important part of introducing interventions like MST-CAN. We want to explore the experience of staff in Leeds Social Services and the MST-CAN team to better understand their experience of collaboration. I'll ask a few basic questions and then some more specific questions about your experiences of working with Children's Social Services/MST-CAN. Do you have any questions before we start?

- What is your job role?
- Where are you based?
- How long have you been qualified for?
- Have you worked with MST-CAN before?

1. What factors helped and hindered the introduction of MST-CAN in Children's Social services?

Prompts:

What made the introductory stages easier?

What made the introductory stages difficult?

Could this have been done differently? If so, how?

2. What is your experience of working with Children's Social Services/MST-CAN?

Prompts:

What is good about working with Children's Social Services/MST-CAN?

What is difficult about working with Children's Social Services/MST-CAN?

Has working with Children's Social Services/MST-CAN impacted on how you work?

Has anyone else in your team referred to MST-CAN? What is your impression of their experience?

3. What is your experience of communication with Children's Social Services/MST-CAN?

Prompts:

When did you first hear about MST-CAN?

How is communication within your team in relation to Children's Social Services/MST-CAN?

How is communication with the other teams and how do they compare (Children's Social Services/MST-CAN/police/schools)?

Has communication changed over time?

Is there anything that would help to improve communication?

4. Who led the introduction of MST-CAN in Children's Social Services you're your perspective?

Prompts:

How did they lead the introduction of MST-CAN?

Did this person/these people have enough knowledge and understanding of the process?

Did this process impact on the way that you work?

Could it have been done differently? If so, how?

Who leads MST-CAN from your perspective, now?

5. How have perceptions and behaviours changed whilst working with MST-CAN/Children's Social Services

Prompts:

Have you been able to maintain your professional identity whilst working with the Children's Social Services/MST-CAN?

What has helped you to maintain your professional identity?

Have your views of Children's Social Services/MST-CAN changed since your first began working together?

Is there anything else you would like to add?

Appendix 3: Email from researcher to participants

Dear X,

As you are aware, I am conducting research exploring staff experience of collaboration between social work and MST-CAN in Leeds Children's Services. I understand that you have expressed an interest in taking part. Please take time to read the attached participant information sheet to consider your participation further.

If you would still like to take part, could you please choose a time slot for your interview using the following link (put in your full name and email address in the text box where it says 'your name'):

http://doodle.com/poll/3xcpguaptmpgvyfk

Once you have completed the poll your information I will contact you closer to the interview time to confirm you would still like to take part and to arrange the location of the interview.

Please let me know if there are any further questions.

I look forward to meeting you soon.

Kind regards,
Steven

Steven Mayers
Psychologist in Clinical Training
Clinical Psychology | Leeds Institute of Health Sciences
Charles Thackrah Building | 101 Clarendon Road | University of Leeds |
Leeds LS2 9LJ
umstm@leeds.ac.uk

Appendix 4: Participant information sheet version 2

Collaboration between MST-CAN and Leeds Children's Social Services

UNIVERSITY OF LEEDS

Information about the research

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Please ask us if anything is unclear or you would like further information.

What is the purpose of the study?

It can be difficult to introduce new evidence-based interventions into clinical practice. Little is known about what leads to successful introduction of these interventions. There is a new evidence-based intervention that is being introduced in Leeds Children's Services, Multi-Systemic Therapy for Child Abuse and Neglect (MST-CAN).

Previous research shows that collaboration is an important part of introducing interventions like MST-CAN. We want to explore the experience of staff in Leeds Social Services and the MST-CAN team to better understand their experience of collaboration. This information will help us better understand what is important. I intend to interview 15 staff and managers in Leeds, who are involved in the introduction of MST-CAN. The interviews will last approximately 1-hour each. Once this is complete, I will transcribe and analyse the data. This research will help us to understanding what factors lead to successful introduction of new interventions.

Why have I been chosen?

We want to explore the views of members of the social services team and the MST-CAN team because of your experience of collaboration. We are aiming to interview up to 15 people in total.

Do I have to take part?

It is up to you to decide whether to take part or not. We will describe the study and go through this information sheet with you if you prefer. If you agree to take part in this study, you will be asked to sign a consent form. If you decide to take part you are still free to withdraw up until one week after the interview, without giving any reason. After one week the data will be anonymised and analysed.

What will I have to do if I agree to take part?

A researcher will arrange to meet you for a one to one interview at your workplace at a time convenient to you. This interview will take approximately one hour and will be audio-recorded. During the interview, you will be asked questions about your views of collaboration between Leeds Social Services and MST-CAN. When we have got the information we need from the audio recording, the recorded interview will be destroyed.

Are there any possible advantages of taking part?

Your involvement may help improve the way in which services like MST-CAN are introduced in the future.

Are there any possible disadvantages and risk of taking part?

There are no personal disadvantages or risks of taking part.

What happens to information about me and answers that I give?

All information that is collected about you during the course of the research will be kept strictly confidential. Your name will be removed from any information you give so that you cannot be recognised from it. Your details will be held securely on a database and deleted once the study is complete.

Direct quotes from the interviews may be used when reporting the findings of the research. This will be kept confidential and anonymous by removing any identifying information about you from these quotes.

What will happen to the results of the research study?

They will be used to help improve understanding and develop procedures for improving collaboration between professionals.

Who is carrying out the research?

This project is being carried out by researchers at the University of Leeds.

Who has reviewed the study?

This research has received ethical approval from the University of Leeds School of Medicine Research Ethics Committee (ref: 14/096). Additional approval has been given by the Director of Children's Services in Leeds.

Who can I contact for further information?

Either:	**At:**
Steven Mayers: umstm@leeds.ac.uk Prof David Cottrell: D.J.Cottrell@leeds.ac.uk Dr Shenaz Ahmed: S.Ahmed@leeds.ac.uk	Charles Thackrah Building Leeds Institute of Health Sciences University of Leeds 101 Clarendon Road Woodhouse Leeds, LS2 9JL

You will be given a copy of this information sheet and a signed consent form for your own records.

Version 2 **Date:** 21st August 2015

Appendix 5: Consent form version 2

UNIVERSITY OF LEEDS

Collaboration between MST-CAN and Leeds Children's Social Services

Researchers: Steven Mayers, Professor David Cottrell and Dr Shenaz Ahmed

Consent Form

	Please initial box
• I have read and understand the information sheet dated 21st August 2015 (version 2) for the above study.	☐
• I have had the opportunity to consider the information and to ask questions about the above study.	☐
• I am satisfied with the answers to my questions.	☐
• I understand that my participation is voluntary and that I am free to withdraw from the study at any point within a week of the one to one interview without having to give any reason and without my legal rights being affected. After one week, data collected during the interview will not be able to be removed from the analysis	☐
• I agree to take part in the above study.	☐
• I agree to the interview being audio recorded.	☐

Name of participant: _____ ***Signature:*** _____ ***Date:*** _____

Name of researcher: _____ ***Signature:*** _____ ***Date:*** _____

Version 2 – 21/08/2015

Appendix 6: Confirmation of ethical approval

UNIVERSITY OF LEEDS

Faculty of Medicine and Health Research Office
School of Medicine Research Ethics Committee (SoMREC)

Room 10.111b, level 10
Worsley Building
Clarendon Way
Leeds, LS2 9NL
United Kingdom

✆ +44 (0) 113 343 1642

14 September 2015

Mr Steven Mayers
Doctorate in Clinical Psychology
Leeds Institute of Health Sciences
School of Medicine
Faculty of Medicine and Health
Charles Thackrah Building, Rm G.04
101 Clarendon Road
LEEDS LS2 9LJ

Dear Steven

Ref no: **SoMREC/14/096**

Title: **Introducing an evidence-based intervention: exploring the experience of collaboration between front-line and specialist practitioners. A thematic analysis**

Your research application has been reviewed by the School of Medicine Ethics Committee (SoMREC) and we can confirm that ethics approval is granted based on the following documentation received from you.

Document	*Version*	*Date Submitted*
Ethical Review Form Version 2	2	21/08/2015
Appendix 1 -Information sheet version 2	2	05/09/2015
Appendix 2 Consent Form version 2	2	05/09/2015
Appendix 3 Topic Guide	1	17/07/2015
Appendix 4 letter to director of social services	1	17/07/2015
Risk assessment	1	07/09/2015

Please notify the committee if you intend to make any amendments to the original research ethics application or documentation. All changes must receive ethics approval prior to implementation. Please contact the Faculty Research Ethics Administrator for further information (fmhuniethics@leeds.ac.uk)

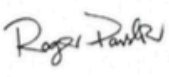
Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

We wish you every success with the project.

Yours sincerely



Dr Roger Parlsow
Co-Chair, SoMREC, University of Leeds

Dr Ruth Brooke
Co-Chair, SoMREC, University of Leeds

(Approval granted by Co-Chair Dr Ruth Brooke on behalf of committee)

Appendix 7: Approval from Director of Leeds Children's Social Work Services

Leeds CITY COUNCIL

Steve Mayers

Children's Services
PO Box 837
Leeds
LS1 9PZ

Contact: Stephen Walker
Tel: 0113 37 83689
Minicom: 0113 222 4410
steve.walker@leeds.gov.uk

Date: 7 August 2015

Dear Steve

Thank you for your letter and documents outlining your planned study in relation to MST-CAN.

I am aware that this has previously been discussed at the MST steering group and very much welcomed as an adjunct to the existing research and evaluation being conducted by Cindy Swensson.

I am happy to support your progress with this interesting project subject to the necessary ethical approval which I understand you are awaiting from within the University of Leeds.

Please liaise directly with Emma Ross MST Programme Manager when your approval is granted.

Yours sincerely

Stephen Walker
Deputy Director of Children's Services
Safeguarding, Specialist and Targeted Services