Exploring Drivers and Barriers: Working in Multiprofessional Teams to Support Children and Families

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Abstract

For some children, additional help sought from specialists outside of school may be crucial for them to engage successfully with their education. How effectively educationalists and these professionals from a wider field interact will have a significant impact upon the support the child receives. This research set out to better understand approaches that help and hinder multiprofessional working for the benefit of the child and their family in the United Kingdom (U.K.). Literature suggests that although there are many benefits accessed by working in multiprofessional teams, the reality is that such collaborative working is beleaguered with challenges. Through a constructivist approach we sought to find out more about the lived experience of professionals in being part of a child and family support team. Using an anonymous survey, we asked a range of professionals questions designed to elicit both quantitative and qualitative data. We were surprised to find that the categories such as age and gender that we had presumed would impact confidence did not; likewise, external restrictions such as time and funding had minimal sway on functionality. Instead, our data suggests that a positive experience is almost entirely based upon the quality of respectful, interpersonal relationships.

Key Words: multiprofessional, teamwork, communication, the team around the child, respect, drivers, barriers, families, specialists, United Kingdom

Introduction

In this article we explore the results of an electronic survey that went out to a wide range of professionals who work collaboratively in the children and families' sector. In the U.K., this sector can include any organization across the fields of education, social welfare, medicine, or varied charities, which contributes to the well-being of the child within the family. When a child in school is recognized as having additional needs which are beyond the scope of service that the school alone can provide, other agencies will be called upon to maximize the child's chance of educational success. The respondents to our survey were predominantly from the U.K., but a very small number of our respondents were international.

As authors, we share personal experience of being involved in multiprofessional interventions in schools, as well as training the future workforce in this area as tutors on university degrees programs. Using our combined access to a wide landscape of individuals, we sent out an anonymous survey to find out more about the lived experience of those who had worked within a multiprofessional team (MPT). What we discovered was that the individual's confidence within this context was far less effected by the categories that we had presumed would impact and far more dependent upon the interpersonal relationships created within the group.

We are aware of the plethora of terminology used around collaborative, multiagency, or multiprofessional working, and have chosen to avoid semantic confusion by using the terms "multiprofessional teams" or "multiprofessional working" (MPTs or MPW, respectively) in a very general sense, throughout. What we are interested in is the "essence" of that MPW, the personal experience of a group of multiskilled professionals involved in a child-centered task together, rather than the policy or even service level mechanics of it. Before we explore our approach to and the results of this research, it is important to explore the current context within which the research was carried out. Although carried out in England and predominantly presenting the views of those currently working in the U.K., the ideas emerging from this are applicable to all MPTs working collaboratively for the benefit of the child.

Literature Review

The Historical Context of Multiprofessional Working

The development of MPW in the U.K. can be traced back to the 1980s and 1990s, during which time both Conservative and Labour governments challenged the efficacy of what education, social, health, and crime services were doing. Media coverage of failed services, such as the media furor surrounding

the Victoria Climbie case (a young girl who died in shockingly cruel circumstances at the hands of her own relatives, despite the interventions of a number of services, due to the failure of those services to effectively communicate with one another, see Laming, 2003), alongside a political agenda that suggested public services were overpaid and underworked, created an environment where change became essential. The New Labour Government (who were in power in England from 1994 until 2010) recognized that social problems were not separate from economic issues and instigated a range of reforms aimed at supporting families with *joined up* working (Anning et al., 2010). Joined up working refers to working across organizational boundaries, using diverse professional knowledge and skills to provide the best support for families. This was an attempt to open effectual streams of communication between separate services that cases such as Victoria Climbie's had exposed as being lacking. New Labour's *Every Child Matters* agenda (DfES, 2003) championed the concept of services working more closely together through strategies such as the "Common Assessment Framework" that built upon the emerging notion of the "Team Around the Child" (Limbrick-Spencer, 2001). Successive governments in England have continued to stress the need for effective multiagency working. Anning et al. (2010) explained that the term multiagency can refer to groups brought together to work on a specific case with a child, be it a group of professionals working together longer term on a specific element of service—such as health care for adolescents—or a specific project relevant to the local area, but the terminology itself is often used fluidly and interchangeably.

Despite the commitment to a more collaborative approach to children's services being established in England almost 20 years ago, there have since been several reviews reporting systemic failures in communication within the education and care systems which have led to tragic results for the children involved (see, e.g., Haringey Safeguarding Children Board, 2009; Plymouth Safeguarding Children Board, 2010; Coventry Safeguarding Children Board, 2013). Wearmouth (2019) suggests that this is in part due to the separate legislative frameworks that education, health, and social services must work within and the different priorities, funding demands, and diverse definitions of what "need" is within a particular organization. It seems that the "messy, disorganized" (2016, p. 10) nature of this work is not restricted to the U.K., with Anderson sharing very similar experiences in the United States. Howarth and Morrison (2007) go so far as to question *why* multiagency working is always assumed to be desirable, despite the widely recognized problems of making it work on the ground. These challenges have been outlined by authors including Limbrick (2009).

The relatively new *Special Educational Needs (SEN) Code of Practice* (DfE, 2015) in England continues to support the notion of professional collaboration,

citing government reports such as *Support and Aspiration* (DfE, 2011) as evidence. This particular report states that when children and families have received relevant support and guidance from specialist services swiftly, it has made "a powerful difference to the children's progress and their happiness in schools" (DfE, 2011, p. 100). *The SEN Code of Practice* includes a chapter about "Working together across education, health, and care for joint outcomes" (DfE, 2015, p. 37) and refers to multiagency and multidisciplinary working throughout the document. The *Code* also introduced the concept of the Local Offer, which outlines what provision is available in the area for children and young people from the sectors of education, health, and social care.

Barriers and Drivers to Multiprofessional Working

Despite the consistent recognition of its value in legislation and policy guidance since its introduction, joined up working across and between professionals working with children, young people, and their families continues to present challenges. Robinson and Cottrell (2005) highlight that, at a practical level, working together might be difficult due to various Information Technology (IT) systems not enabling the sharing of information adequately. In addition, concerns about data protection inhibiting exactly *what* can be communicated by different organizations has been recognized by various authors (e.g., Buckley et al., 2020; Hellawell, 2019). The other challenging aspects of MPW mentioned by these authors include the duplication of processes and paperwork between different agencies, along with time to attend meetings regularly. Time, of course, is essential if people from different organizations are to meet, learn what each person or team does, develop a professional understanding of the different expertise available within the group, and then develop a MPT which builds on these strengths. Without this, the risk is to remain in what Warmington (2011) terms as the "heroic" stage (p. 153), where individuals and small teams are doing things which are innovative but remain localized and have little or no impact on changing the organization or systems, thus maintaining silos of working practices.

The stages of developing an effective team, as outlined above, are even less likely to be met when the makeup of the team is unstable. Close (2012) explains how membership of a MPT is likely to be fluid at best. Frequently there will be a small number of people making up the core, with others joining and leaving due to conflicting demands on their time, changing roles, and priorities. Close (2012) suggests that, despite a general understanding of the important role professional cultures play in the development and maintenance of successful MPT working and the need to create a shared vision which values the diversity of the group and each person (Kortleven et al., 2019), the time

needed is rarely available for this. Additionally, Warmington (2011) has suggested that regardless of how successful the team is and how valued members feel, barriers from vertical hierarchies between staff and their managers from any one organization can lead to tensions within the group, impacting on their ability to actively participate in the MPT (Warmington, 2011).

Much of the literature surrounding MPTs suggests that those involved value the professional knowledge and expertise brought to the group by members from other agencies (Frost, 2017). Yet at the same time, there is evidence highlighting the lack of professional trust between different groups (Ekins, 2015). Professional boundaries can lead to competition between groups, rather than cooperation, especially if there has not been any consideration of the various values and priorities each group is trying to achieve (Rose & Norwich, 2014). Belief that certain professions (and professionals) are automatically "in charge" because of their role can also lead to competing power struggles and inhibit active and meaningful contributions from others who see themselves as less qualified or valuable to the team (Harris & Allen, 2011), something Hood (2015) terms as "implicit professional hierarchy" (p. 148). Staff in roles that may be viewed as common or generic, such as teacher or carer, are sometimes afforded fewer opportunities to actively participate in MPTs. In contrast, staff in specific, specialist roles with higher level qualifications and status, for example, paediatricians and psychologists, tend to be the voices which dominate meetings, even when their engagement with the child or family is minimal (Anning et al., 2010; Limbrick, 2012). This reflects a traditional medical model view of working with children, which focuses only on each individual need, ignoring the interconnected nature of a child's needs which can benefit from a holistic approach incorporating different perspectives from education, health, and social care (Moran et al., 2006).

Participating in generic roles can be valuable for all members of the MPT, as all the team gain an understanding of the work being carried out by each member (Gaskell & Leadbetter, 2009), but some professionals struggle to let others complete their role-specific tasks because they question whether the work will be of poorer quality (Rose & Norwich, 2014). The sharing of role-specific expertise within a MPT can cause individuals to question their own professional identity and can lead to some retreating from the work of the group if they no longer feel needed (Kortleven et al., 2019). Successful MPTs value and use expert knowledge, with the team drawing on different skills for the *greater good* of the group and the perceived benefits for the service users (Herbert & Broomfield, 2019; Rose, 2011). However, Howarth and Morrison (2007) note that very little research has been done into exploring the relationships within MPTs, instead it has tended to focus upon the structural and systems

barriers which often inhibit practice. Notions of "how we do things around here" might need to be challenged if MPTs are to be successful, with a renewed focus upon the differences, similarities, and ambiguities between each member of the team and their unique roles before momentum can be developed to move forward (Martin, 1992).

Despite the apparent barriers to MPW, strong evidence still exists for its benefits. Herbert and Broomfield (2019) share how in their research almost all professionals, regardless of background, recognized the value of joined up working and could see how they had learned and developed through participation. Professional collaboration can support early intervention with children and families, as well as reducing duplication of assessment and enabling others to learn new approaches to effective support for children and their families (McConnellogue, 2011). Finally, Workman and Pickard (2010) recognized the positive impact of time, in that the perceived threats to professional identity mentioned above were lessened as MPTs continued to work together and team members could see how their roles were strengthened, not diminished, by being part of the team.

Research Methodology

This research took a constructivist approach to the topic of MPTs in that it sought to better understand the lived experience of the participants in relation to their involvement in MPW. Our approach respected that the experience of each respondent would be different, constructed by their individual interaction within their social group or groups (Bryman, 2016). We accepted that each respondent's own perception of MPW and their role within it would be based upon their professional training and experience, and this would, in all likelihood, result in differing conclusions about the actions necessary to address clients' needs or solve a particular problem. Our data collection tool, an anonymous electronic survey, was designed to fit our aim—to find out more about the workings of MPTs—in the most accessible way possible. Ethical clearance for the research was obtained through the University of Wolverhampton, and the British Educational Research Association (2018) *Ethical Guidelines* were adhered to throughout.

Silverman (2001) discusses how qualitative research is frequently viewed as the poor relation to its quantitative cousin; however, he stresses that "there are areas of social reality which such statistics cannot measure" (p. 32). Although we took a constructivist and thus classically qualitative approach to this research, we did not restrict ourselves to just one type of data. As well as seeking descriptive detail of MPW experiences, we were also interested in quantitative

aspects, such as how the age or years of experience might impact upon the individual. As a result, we designed a single survey which sought brief, quantitative responses as well as fuller, "thick descriptions" (Geertz, 1973) through both closed and open-ended questions. We carefully designed our survey questions so as not to make assumptions about the way in which respondents could answer, but we acknowledge that our selection of questions in themselves would have indicated to the respondent the type of data that we were seeking. As McGrath and Coles (2013) argue, it is only possible to approach research with an open mind, not an empty one.

The survey was distributed through the academic and organizational channels of the researchers (including email and social media), with the request that it be passed on to anyone in an education, care, or support role working with children and families. Because of this, we do not know the final number of recipients that it reached, but we received 53 completed surveys.

The respondents comprised an extremely wide range of roles and responsibilities within the children and families' workforce, including, but not limited to: psychologists, doulas, speech therapists, teachers, and social workers. At least one response was (unexpectedly) international. We had not foreseen this, and it is possible, from the terminology used, that at least one further response was from a professional outside of the U.K., although they do not specifically state this. Our study does not pretend to summarize the experience of all when working within multiprofessional collaborations, but this small sample does enable us to tentatively suggest some "fuzzy generalizations" (Bassey, 1998) about the wider population to which this unit belongs (Cohen & Manion, 1989) which are worth considering further.

Data Analysis

Qualitative data can never be approached totally objectively; it will be filtered through the bias of both respondent (Goodson & Sikes, 2001, p. 25) and researcher. Because of this it was important that we as researchers were as reflective and reflexive as possible. The closed questions provided opportunity to access an overview of factors such as: age, gender, roles, qualifications, years of experience, and years in current role (see Table 1). Likert scales were used to provide an indication of each respondents' experience within a MPT: how confident they felt, their perception of the way that their ideas were received, their level of responsibility in moving actions on, and so forth. This provided a cache of quantitative data that could be compared across categories of response.

After the eight closed questions, a further eight questions invited fuller responses, for example, the invitation to describe a scenario where a MPT worked particularly effectively and to reflect upon what made it effective. The responses

to these open questions were approached thematically. First the researcher became familiar with the qualitative data and then "stood back" (Wellington, 2015) from it to reflect upon the key themes emerging. These themes were then confirmed by the second researcher in order to make the conclusions reached as robust as possible. After this came the task of "pulling apart" the data (Wellington, 2015) and recombining it as organized themes in a data reduction grid. Those identified themes are discussed below.

Data Presentation

The first surprise when we explored the quantitative data was the diversity in the range of roles held by professionals working with children and families. Although around 20 respondents held roles within educational settings, there were over 20 diverse professions represented in the remainder of this small sample. Similarly, we had over 20 work settings listed in responses, varying from the National Health Service (the U.K.'s state medical service) to community workers to mental health charities. The amount of time that respondents held their current role also varied drastically, from less than a month to over 40 years. It was not a surprise that 85% of the respondents were female, as this reflects the composition of the caring professions in the U.K. in general, but it was a concern that over half of the sample were aged 50 or over. Although it is possible that this particular age group were simply more willing to respond to the call to take part in the survey, it could also suggest an aging workforce, creating uncertainty around continuity within the sector. As you read through the data you will notice that the lack of responses from pediatricians within the sample is significant.

Considering the quantitative data, it quickly became clear just how many suppositions we had brought to the research as professionals working in a higher education sector where inexperienced students (the majority of which were young women working in the early childhood sector) would frequently bemoan how they were "not listened to" because of their role and inexperience. What was soon evident was how mistaken we were in these. For example, taking "my ideas are valued" as an indication of an individual's perceived confidence and competence within a MPT, it quickly became clear that **this was *not* dependent upon gender, age, role, or experience**, as is demonstrated in Table 1 below. In fact, the only apparent "pattern" across this quantitative data was that there was no pattern at all. The only area where there was *some* correlation was between confidence and length of time in the role. The average length of time for those less confident in their role was six years compared to 13 years for those that were more confident. However, even this was inconsistent, as individuals with 12 years of experience were found in the "least confident" category, and those with less than a year's experience in the "most confident" category.

Table 1. Responses to "My ideas are valued" Correlated With Role, Time in Role, Age, Gender and Qualification

Rating of "My ideas are valued"	Role and Number Assigned		Time in Role	Age Range	Gender	Qualifications
Very Rarely	Teaching Assistant (TA, Doula)	1	6 y	40–49	F	Degree
Sometimes	Support coordinator (Secondary)	4	4 y	22–29	F	Prof Q
	Psychologist (Early Years team lead)	6	3 y	40–49	F	UGD
	Advocate (Disability)	38	12 y	40–49	M	PGD
	SENCO and Head teacher (4–11)	50	3 y	50+	F	UGD
	Early Years Educator (birth–8)	3	2 y	50+	F	Prof Q
	University Lecturer	14	17 y	50+	M	PGD
	Youth and Behaviour Lead	18	3 y	40–49	F	PGD
	Head teacher (age unspecified)	22	16 y	50+	F	UGD
	Teacher and SENCO (primary)	23	7 y	50+	F	UGD
	Teacher (children aged 4–11)	29	5 y	22–29	F	PGD
	Head teacher (school for children with SEN)	39	11 m	40–49	F	PGD
	Team leader (unspecified)	42	3 y	22–29	M	UGD
	Operational Manager (charity)	49	7 y	50+	F	UGD
Most of the Time	Manager (and SENCO) (birth–8)	8	26 y	40–49	F	PGD
	Teacher (age range unspecified)	10	1m	22–29	F	UGD
	Omitted	11	Omitted	50+	F	N/A
	Teacher (age range unspecified)	24	12 y	50+	F	PGD
	Charity worker	25	6 y	50+	F	UGD
	Early Years lead	27	5 y	50+	F	UGD
	Social worker	28	6 m	50+	F	UGD
	Early Years Manager	32	25 y	50+	F	PGD
	Higher Level TA	35	9 y	50+	F	Prof Q
	Training lead (charity)	36	5 y	30–39	F	PGD
	Administration Lead (Government disability advisor)	37	3 y	50+	M	Prof Q
	Regional Coordinator of the European Citizen's Initiative	41	35 y	50+	F	PGD
	Manager (Early Years)	43	7 m	40–49	F	UGD
	Nurse (National Health Service)	44	15 y	50+	F	Prof Q
	Teacher and SENCO (4–11)	47	2 y	30–39	F	PGD
	Child and Adolescent Mental Health Services (psychologist)	48	5 y	40–49	M	PGD
	Teacher and SENCO (4–11)	52	1 y	30–39	F	PGD
	SENCO/ Assistant Head Teacher (4–11)	54	3.5 y	40–49	F	UGD

Table 1, Continued

Almost Always	TA (SEN school)	2	10 y	50+	F	UGD
	Tutor (unspecified)	5	20 y	50+	M	NA
	Academic (Professor in Higher Education)	7	40 y	50+	F	PGD
	Speech And Language Therapist (SALT)	9	23 y	50+	O	UGD
	Psychologist (birth–8 Intervention)	12	10 y	40–49	F	UGD
	Teacher and Specialist teacher (SEN, 4–11)	13	5 y	40–49	F	UGD
	Child Psychologist	15	14 y	30–39	F	PGD
	Social and Behaviour Change and Gender Director	16	9 m	50+	F	PGD
	Epidemiologist (US Dept of Health)	17	1 m	22–29	F	PGD
	Advocacy (sign language interpreter)	19	36 y	50+	M	Prof Q
	SEN Advisor	21	20 y	50+	F	Prof Q
	Teacher (children aged 11–16)	26	2 y	22–29	F	UGD
	Manager (birth–8)	30	17 y	50 +	F	Prof Q
	Director (birth–8)	31	3 y	40–49	F	Prof Q
	Specialist Teacher (SEN school)	33	13 y	50 +	F	UGD
	Assistant Head Teacher (age range unspecified)	34	6 y	40–49	F	PGD
	Teacher (birth–8)	40	20 y	50+	F	UGD
	Specialist Support	45	11 y	50+	F	Prof Q
	SALT	51	10 y	30–39	F	UGD
	SALT	53	20y	40–49	F	PGD

Notes. y = years; m = months. Survey gender options: Male (M), Female (F), or Other (O). Qualifications: Undergraduate Degree (UGD), Postgraduate Diploma/ (PGD), Professional Qualification (Prof Q). SENCO = Special Educational Needs Coordinator

The random nature of the quantitative data made it even more important to unpack the qualitative data to get a clearer picture of what *did* make a successful or unsuccessful experience of MPW for the individual. Fifty respondents responded to the open-ended questions, although two only partially. The responses varied from extremely brief comments to very full, detailed responses. The themes that emerged are explored below. Please note that the status of the child and family within the MPT is deliberately absent from the following discussion, although very much an aspect of the data that was collected; our capacity for this article was limited, and so we have reserved this topic for our next publication. We have deliberately not identified the profession of those making the comment, as what became very apparent was that the following experiences existed universally across all roles represented in our sample.

Therefore, "respondent" or "professional" is used throughout. Each of the 53 responders was assigned a number so that you can see the range of responses across our participants, and the words of the respondent are made clear by being italicised.

What Things Prevent Successful Multiprofessional Working? What Are the Barriers?

Professional Hierarchy

The fact that some roles were perceived as "*more powerful than others*" (11) was mentioned by over a third of the respondents and was most frequently mentioned in connection with clinical professionals. The data suggests that the difference between a medical model of the child and a holistic view of the child caused regular conflict within MPTs. One respondent stated, "*Doctors are the bosses"* (6), and another, who felt that "*power discourses [were] are evident*," perceived "*Pediatricians on the higher tier"* (8). This professional seemed to have struggled significantly with this:

> The pediatrician dismissed my opinion, contradicted me in public (not, thankfully, in front of the parents) and put the child on a different pathway.…It's only with pediatricians, never with other team members. We have a team (of professionals) where we're all equally important, though some have greater or lesser roles to play at different times, depending on the needs of the child…I am ashamed to say we don't address it and just work around it. (9)

The above comment suggests that other professionals did not feel entitled to challenge the medical opinion and instead adapted their work to fit with what they believed were incorrect decisions.

Similarly, a respondent commented that "*pediatricians and psychiatrists are more likely to ignore/overrule my ideas or listen but not change their course of action*" because "*they are trained to be decision makers and are tied to the 'medical model' of thinking about a situation, whereas the ideas I have are usually contextual and about the system rather than 'within child'*" (15). Psychologists also come in the firing line as the following respondent comments that they will often "*contribute to a team discussion in a way that others perceive as condescending*" (48). And in another professional's view, the fact that "*educational psychologists are often gate keepers to accessing further funding*" means that they are often perceived as being "*valued higher than the rest of the team*" (53). The following respondent explained how: "*In a meeting it is always the profession with the*

highest qualification who everyone listens to, the psychologist or GP [general practitioner], and they have probably spent the least time with the child" (21).

This perceived hierarchy certainly was not only confined to a divide between clinical professional and "other"; one respondent commented that, in general, there was less respect shown for those with a "*lack of qualification, knowledge, or experience*" (1). Conversely, another professional stressed that although there were some "*instances where professionals requiring a qualification (e.g., social work/health) will use this to push their opinion and don't always take into account the view of other professionals who may have a better knowledge of the family*" (25), these occasions did appear to be few and far between. The following respondent felt that it was not the actual qualification but the context that the individual team member worked within which caused the bias, and that it was often the case "*that the EY [Early Years] practitioner or nursery SENCO [Special Educational Needs Coordinator] is at the lower tier level*" (8).

There was also a perceived hierarchy caused by rank, whereby "*the views of staff who may have good knowledge but are in a less senior position are not always respected equally*" (25). Or, put simply by another respondent, "*my headteacher outranks and overrules me*" (52). One professional stated that "t*he managers are treated completely differently. Those in charge are really not to be questioned*" (3). Further to this, one respondent explained how they felt that they could achieve very little without the support of someone in a more senior position, adding: "*If you are in a low position, you can't force a person who is acting as a barrier, you have to rely on someone at high level, who may be hesitant*" (38). Another respondent suggested that it was not so much rank as "*controlling personalities*" (16) that caused problems, as appears to be the issue in this case: "*The EHCP [Education Health Care Plan, a personalized plan put in place by those supporting a child with additional needs] coordinator is able to ignore the school, parent, and Ed Psych[ologist]'s wishes/recommendations and write whatever they want on a final plan*" (52). The problem with hierarchy, the following professional argues, is that it "*brings about bureaucracy and limits autonomy and innovative thinking*" (18).

Poor Communication

A predictable barrier to the efficacy of MPW was, predictably, "*lacunae in communication*" (36). There were the expected practical difficulties, such as: health teams being particularly "*hard to contact*," having to "*leave messages with secretaries or fill in forms*" (47) and a general lack of response. Plus experiences such as this were common: "*The day was spent trying to contact her social worker, Duty protection team, etc.; I felt overwhelmed; no direct contact or support. No*

returned phone calls" (8), as were those "*many meetings [where] the professionals are unavailable [or] don't attend at the last minute*" (54).

However, there was also what was presented as a more deliberate lack of communication. Situations when other professionals simply "*wouldn't listen*" (23) were mentioned. This respondent explained how:

> There was no sense of urgency for the child and no responsibility from the LA [Local Authority, that is, local government services] for chasing up the appropriate staff to facilitate the move. Neither myself, or the receiving school, were communicated with, and the LA did not follow up when responses to requests to neighboring LA were not responded to. (50)

Our data presents evidence of failures to share information (22, 44), to the point that "*poor communication*" was equated with a "*lack of professionalism and honesty*" (52). There is also data indicating that some professionals simply did not fulfill what they had agreed to do. For example, one respondent explained how they were "*not able to get the Health Visiting team to follow up with visits and phone calls to the parent when it was agreed…saying they would do something, but then not doing it*" (53).

Lack of Shared Understanding/Goal

This area can be summed up with this comment:

> Silo working is the most common barrier. People looking at within child factors in relation to their area of expertise only, not the system around the child and how that functions, with the advice given (15).

This limited view of the child, based around the priority of, or expertise of, those leading the case was mentioned several times; as one respondent put it: "*not all stakeholders are playing on the same team, and many have their own separate agendas*" (5). For example, one respondent discussed how, when working with a particular family, the older child's education became the priority with the school taking a lead, and as a consequence the needs of the younger child at home were overlooked (32).

"*Antagonistic perspectives and analyses of the situation, without a unifying view*" (12) arose as the cause of many challenges, such as members of the professional team being "*unable to free themselves from value judgments and assume an exempt and objective perspective*" (12). In some cases, this occurred to the extent of other perspectives simply being a bother, as in this example:

> My headteacher, who by their own admission is not SEND [Special Educational Need and Disability]-savvy, can make my job tricky. In my opinion (and that of other professionals), their vision for the school does

> not support or benefit those with SEND, and it feels like SEND is a "hassle" for them. (52)

Whether this lack of shared vision stems from a lack of understanding (mentioned by: 1, 9, 12, 13, 15, 27, 33, 37,42, 54), a lack of professionalism (mentioned by: 14, 16, 18, 25, 27, 32, 45, 48, 50, 52), or simply from idleness (mentioned by: 6, 21, 38, 44, 53), it is unclear. But the result is always the same, a lack of progress, as in this case, where: "*neither could decide whose case load he should be on, and it was not resolved*" (21).

Egos, Arrogance, and a Lack of Confidence

Examples of egotistical or arrogant behavior were peppered throughout the responses, the types of phrases used are listed below:

- *We "know better"* (6)
- *An arrogance that he knows best—that he's in charge* (9)
- *Power, insecurity* (11)
- *Ego, greed, and selfishness* (14)
- *Too many professionals and too many egos and agendas* (32)

Interestingly, some of the respondents related this type of behavior as stemming from defensiveness or emerging from a lack of confidence (24, 40). As one respondent explained, because of insecurity, some professionals did not like to have their "*comfort zone"* (38) disturbed. Again, this ultimately impacted upon the client:

> Everyone was very protective of their knowledge and wary of each other…building professional relationships, respecting opinions, accepting others' opinions, and putting into practice overcame them. [There is] protectiveness of own professions and not wanting to be overrun by other professionals—to the detriment of the person being supported. (45)

As another professional described, sometimes a lack of confidence could cause people to "*put up defensive barriers and work with blinkers on*" (44).

Lack of Funds/Manpower

It is significant that funding and staffing was mentioned by just 11 respondents, so around 21%, whereas a lack of a shared vision was mentioned by over half. In terms of practicalities the responses were fairly predictable: lack of funds (24, 27, 32), lack of manpower (25, 27, 28, 34, 35, 36, 47), and long waiting lists (27, 51). One respondent commented that these restrictions stopped people from "*being allowed to say what they really think"* (24) and stopped key players from being able to attend meetings, sometimes resulting in decisions

for the child being made on extremely limited evidence (34). One respondent commented that even within this frugal landscape, resources were still being wasted on the duplication of records due to policy and procedure (28).

When It Works Well: The Drivers

Effective Communication

Predictably, over half of the respondents specifically referred to effective communication as being key to the most successful MPTs. Below are just a selection of the responses referring to this aspect:

- *Sharing information to fully understand the case* (2)
- *Collaboration and open dialogue…good open communication* (11)
- *Purposeful discussion and an insistence on honesty* (22)
- *Good communication* (25)
- *Communication is key* (26)
- *Communication and understanding* (27)
- *Effective communication* (28)
- *Excellent communication, regular meetings* (31)
- *All professionals involved having direct discursive input to the meetings and decisions…professionals and parents were willing to share and listen to each other* (34)
- *Group discussions…open communication and detailed discussion* (36)
- *Everybody's views being considered* (50)
- *Good communication and persistence* (52)

So, what made communication effective? Sincerity was mentioned several times, as was openness. This respondent described successful communication as: "*effective, honest, transparent, and clear"* (28). Another respondent expanded upon the significance of honesty by specifically relating it to the acknowledgement of the more ineffective aspects of their teamwork, within a trusting environment, referring to the creation of "*safe spaces*" in order "*to both celebrate success and work on areas that need improvement*" (36).

Something that made successful, safe spaces was a lack of professional hierarchy. It was stressed that within effective teams "*ALL"* (1) participants were listened to, "*regardless of role"* (29). Fruitful collaborations were based upon "*hearing each other as well as respecting each other"* (38). Listening, rather than just hearing, was a term used several times, and one respondent explained successful communication this way: "*When all members listened to each other and valued what they were saying rather than just waiting to talk*" (49).

When asked what is key to effective MPW, there were several responses which were similar to this: "*We all just need to listen…respect and really listening and being open to one another's viewpoints"* (16). The value placed upon team members feeling *heard* cannot be overemphasized. A fraction under half of the respondents (25 in all) specifically mentioned the importance of their views being genuinely acknowledged. When respondents were asked about an example of MPW where they felt particularly confident, feeling listened to or feeling that opinions were valued outstripped all other responses. As one respondent explained, feeling "*Listened to and reflected upon"* resulted in their feeling "*included*" (49) in the team. Another stressed that "*everyone has to share their opinion; everyone has to listen to others' opinions*" (44).

A perception that opinions were respected was the core of many positive responses. For example, this professional shared: "*The team seeks me out and asks what I think, not just 'How often can you see this child?'*" (9). Proof that opinions were valued was recognized not in just the verbal acknowledgement of ideas, but in individuals' suggestions being "*followed through*" (33) or "*taken on board*" (12). It was interesting that one professional specifically referred to the efficacy of listening as not only being central to the well-being of the child and the family, but also valuable for colleagues' emotional health and professional growth. They explained the importance of "*actively listening to each perspective and recognizing the emotions of each team member…the ability to actively listen to others and support their development*" (12).

Written communication was barely mentioned, although, presumably, an important aspect of the process. Just one respondent highlighted the need for "*excellent records to be kept and shared in a timely way*" (22), but the fact that it is mentioned just once out of 53 responses is significant. The success of a team appears to be far more dependent on relationships than paperwork.

A Shared Aim

For almost half of those that mentioned a common goal, the child was the focus, for example, "*wanting the best outcome for the child*" (23), but the well-being of the family was also recognized as paramount. For example, these two respondents mentioned: "*The shared desire to help the child and make things as easy for the parent as we can*" (9) and that the "*Task and solution*" should be "*timed to family's needs*" (10). Beyond just "*setting clear and concise targets/outcomes*" (13), "*agreed and clear goals*" (32), or a "*common aim*" (2), these objectives also encompassed values. One respondent referred to this as "*common principles and mission*" (12), another said that it was a "*shared culture*" (9), and another that it was a "*shared belief that working together makes a positive difference*" (44). Rather than a target written in an action plan, it was about

"*Knowing what the team, as a whole, needs to achieve, and working together in the same direction*" (36).

Understanding of and Respect for One Another

An aspect that was noted as key to moving forward in a unified way was to know and understand one another's professional context and skills; "*knowing strengths of team members and building on them to complement each other*" (36). This came up numerous times; some examples are given below:

- *Understanding…respecting each professional* (27)
- *Understanding of each other's roles in the process of child well-being/welfare* (44)
- *Understanding each other's clearly defined roles* (53)
- *Partner roles were clearly defined* (14)
- *I appreciate their expertise and the way each individual's mind works* (16)
- *Equity in value of perspectives* (49)
- *I could not do any of my work alone. It really does require a team to make changes. No one profession "knows" it all* (7)
- *The valuing of every professional role and responsibility* (8)
- *Considering strengths of individual team members* (36)

Tied in with the valuing of one another's abilities came respect. The word "respect" was used by 15 respondents. This encompassed respect for each professional's skills set and area of expertise, respect for the role each had to play within the team, respect for one another's boundaries, respect for one another's opinions, and respect for the value that each professional brought to the team. Interestingly, respect was only used once in relation to the treatment of the service user.

The value of sharing and combining previous experiences was viewed as a great strength. One respondent explained the importance of "*shared knowledge to improve individuals*" and how "*sharing examples of practice that went well… was a positive thing to do to move forward*" (44).

Equal Sharing of Workload and Responsibility

The concept of sharing responsibility and working in a joined-up or *fair* way was mentioned repeatedly. There were two aspects to this: first, the equivalent sharing of workload, and then individuals seeing through the task that they have said they will do. One respondent commented that there should be "*Joint everything*" (40); another that there should be "*an agreed sharing of authority, responsibility, and resources*" (37); and another that there should be "*equality among team members*" (9). Successful multiprofessional experiences

were when "*All professionals followed out their roles and actions effectively*" (30), or, quite literally, "*Doing what you say you are going to do"* (53). Intriguingly, one respondent felt that there should be greater accountability placed upon individuals in the team, even to the point of introducing "*a tracking system to note who is the barrier in the flow of work*" (38). It is interesting that the need for an individual or group to take a lead was mentioned by only four respondents, in terms of someone needing to "*make final decisions*" (30).

Discussion

Contrary to some of the issues highlighted by the literature (Robinson & Cottrell, 2005), no problems related to IT or the use of data appeared in our findings. In fact, despite General Data Protection Regulation (GDPR) having now established such a revered position within many institutions, it was not mentioned at all. Additionally, the time aspect, seen as central in so much of the literature (Buckley et al., 2020; Hellawell, 2019), was perceived as a lesser aspect of influence within our results. Within this data set Kortleven et al.'s (2019) ideas of shared culture and Warmington's (2011) ideas of participants feeling valued (and sometimes restricted by vertical hierarchies) were far more evident. In our data it was emotions, feeling valued, and relationships, rather than externally imposed restrictions, that dominated. Our data demonstrate unequivocally that the success of MPTs is based upon people and how effectively they interact, not in organizational processes. This, as Howarth and Morrison (2007) have noted, has previously been relatively unexplored. Our data suggest that MPW is not about structure and procedure, it is about feeling listened to, feeling valued and respected; success is not found in systems, but in the dynamics of personal relationships.

Harris and Allen's (2011) research noted the problem of power struggles in MPTs and how some professionals would automatically take charge; similarly, Ekins (2015) discussed the lack of interprofessional trust and how a sense of competition could hamper MPW. These aspects were all visible in our data. Moran et al. (2006) discussed the conflict that emerged between medical and holistic models of the child, and this also was prolific in our survey responses, as was Anning et al.'s (2010) observation that those with higher level qualifications and status could tend to dominate proceedings, despite them having the least knowledge of the child and family. It is worth noting that none of our respondents were pediatricians or doctors and that an important next step in this research would be to solicit their opinions.

Similar to Workman and Pickard's (2010) findings that insecurities can emerge when professionals first come together, but can reduce with time, three

of our respondents mentioned feeling far more confident when working with teams that were familiar. This was due to the "*mutual respect for each other's skill set and experience*" which emerged from "*years of experience*" (9).

Conclusion

Policy and literature is thick with the organizational strategies and processes of MPTs, but our data suggests that the fruitfulness of this enterprise is firmly embedded within individuals. Success is found in genuine professionals who value the expertise of others and who themselves feel valued. Emotional competency and respect appear to be at the heart of interprofessional relationships, and these are skills that can be developed within a nurturing environment. Our data suggest that for MPW to be effective, a key prerequisite is individual capability to put aside arrogance and insecurity and work with others as equals, as "*professionals with good training and a willingness to learn*" (41). Our respondents discussed the difference that showing humility and being authentically willing to listen to others could make; ultimately, MPW requires acknowledging that no one person holds all of the tools necessary to help a child in need and also requires sharing the "*belief that working together makes a positive difference*" (44).

It is clear from our data that for a MPT to be successful everyone involved must have the capability to look beyond their own professional knowledge and their own ego to the "*big picture*" (50) or the "*mission*" (12). Our data suggest that for MPTs to work well there must be a firm foundation of collective values, a "*shared culture*" (9) that enables the team to keep "*working together in the same direction*" (36). Deal and Kennedy (1983) refer to this as the culture of the organization which keeps the herd "moving roughly west" (p. 14). This is not about accurate notes; this is not about tick boxes or a written plan being distributed appropriately; instead it is a core belief that, for the benefit of the child and the family, "*Working as a team we strengthen skills and we intervene more safely*" (12).

Research by Solvason et al. (2020) highlighted that the key to successful partnership working in the education and care field was holding the needs of the child in mind. The data discussed in this article suggest that professionals can often lose sight of the child whilst focused upon personal agendas, which can become competitive when working side-by-side with those from differing professional backgrounds. This seems paradoxical within caring professions and is something very much worth exploring more deeply through in-depth discussions with professionals in various roles. As Anderson (2016) makes clear when he refers to Hohmann's (1999) work, it is insufficient to simply reach

conclusions about the efficacy of a program, "Instead, the role of the researcher is to investigate for whom the program worked, under what conditions, and why it worked" (p. 16). It would be extremely valuable if pediatricians, who were notably absent from this sample, could be included within that future research. Our research discussed here has identified barriers; our next step is to more fully understand why and for whom they exist and whether they can be dismantled.

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