Health, education and social care professionals’ perspectives on risk and resilience in vulnerable young people and an exploration of the usefulness of this approach in promoting effective multi-agency work.

Thesis

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# Table of Contents

List of Tables 7

Abbreviations 8

Abstract 9

Declaration 10

Copyright statement 11

Acknowledgements 12

Chapter 1:  **Introduction** 13
   An overview 13
   Background 14
   The researcher and reasons for the study 15
   Conceptual frameworks 18
   Risk and resilience 20
   A rationale for the use of the risk and resilience framework 21
   The research questions 24
   Overview of the thesis 24
   Summary 29

Chapter 2:  **Review of Literature** 30
   An overview 30
   Introduction 30
   Background Policy 34
   Multi-agency collaboration: a literature review 40
      *Terminology used* 42
      *Models of multi-agency activity and complexities* 43
   Multi-agency working rationale 45
      *Benefits of multi-agency working* 46
      *Implementation of multi-agency working* 48
      *Effective multi-agency practice* 49
      *Difficulties associated with multi-agency working* 51
   Barriers and facilitators regarding multi-agency working 54
      *Organisational / Structural factors* 56
      *Cultural factors* 57
      *Expert language* 62
      *Health barriers* 63
      *Additional barriers* 66
Summary of difficulties

What then is perhaps needed?

Research

Joint Training

Focus on cultural aspects

Common conceptual framework and language

Conceptual difference

Lack of a common language

The future of multi-agency working

A new way of working

The risk and resilience framework

A brief history of the risk and resilience framework

Risk factors

Protective factors

Resilience

Utilisation of the risk and resilience framework

A rationale for using the risk and resilience framework within a multi-agency setting

Chapter 3: Methodology

An overview

Context

Approach

Research questions

Background

The role of the researcher

Ontology

Research methodology and design

An empirical review of literature

Secondary analysis of school held data

Interviews and questionnaires

Case studies

Field trial

Rationale for methodology selection

Case study design

Use of literature

Secondary analysis of data

Interviews and questionnaires

Interviews

Interviews and research questions

Interview rationale and process

Interview purpose
Chapter 4: Presentation of Findings and Discussion

Overview

Stage 1: Interview responses
An overview

Responses to interview questions
  a) Children at risk of poor outcomes and educational outcomes
  b) Risks that children face within the specific community
  c) Professional views of the major concerns held by children
  d) How professionals identify children at risk of poor educational
  e) Professional understanding of the term resilience
  f) Professional views on the factors that enable a child to become
     resilient to the risk factors encountered
  g) How professionals build resilience with children
  h) Multi-agency links professionals have regarding children
     at risk of poor educational outcomes

Overarching themes and issues arising from professionals
  interviewed
    Professional conceptualisations through discourse
    Lack of a common language
    Critical responses towards other service providers
Stage 2: Questionnaire responses
An overview
Context

Section A: Individual Case Study Pupil

Pupil A
- Background
- How the child is viewed by practitioners
- How practitioners respond to such perceived risks
- Effectiveness of interventions to reduce risks and build resilience

Pupil B
- Background
- How the child is viewed by practitioners
- How practitioners respond to such perceived risks
- Effectiveness of interventions to reduce risks and build resilience

Pupil C
- Background
- How the child is viewed by practitioners
- How practitioners respond to such perceived risks
- Effectiveness of interventions to reduce risks and build resilience

Pupil D
- Background
- How the child is viewed by practitioners
- How practitioners respond to such perceived risks
- Effectiveness of interventions to reduce risks and build resilience

Pupil E
- Background
- How the child is viewed by practitioners
- How practitioners respond to such perceived risks
- Effectiveness of interventions to reduce risks and build resilience

Section B: Analysis of practitioner understandings of risks, resilience and building resilience
- a) Practitioner understanding of risks for poor educational outcomes
- b) Practitioner understanding of resilience and the factors that foster resilience
- bii) Practitioner understanding of building resilience

Section C: Coordination and coherence of provision
Section D: Multi-agency working 236
Conclusion 238

Stage 3: Field trial of the risk and resilience framework 242
An overview 242
Context 242
The developmental multi-agency meeting 243  
   a) Risk factors for poor educational outcomes 244
   b) Protective factors identified 246
   c) Risk and protective factors surfacing 247
   d) Common concerns and priorities 249
A shared strategy 252  
   Agreed actions 253
   How this relates to building resilience 254
Conclusion 255

Stage 4: Research findings and empirical review of literature 259
An overview 259
Multi-agency work 259
Risk factors, protective factors and resilience 260
Conclusion 263

Chapter 5: Conclusion and Recommendations 265
An overview 265
Thesis: aims and research questions 265
Research findings 266
Contribution to knowledge: locating the findings within the literature 274  
   Risk, protective factor and resilience 275
   Multi-agency work 276
   Professional conceptualisations 279
   Risk and resilience framework 281
Summary 283
Limitations to the study 285  
   With regard to literature review 285
   With regard to methodology 285
Complexities if the dual role of researcher and practitioner 287
Reflections 288
Implications for policy and practice 290

Bibliography 291
Appendices 314
Tables

Table 1 The varying aspects areas and subfields of multi-agency working stemming from the review of literature. 41

Table 2 Terms of reference for multi-agency working taken from Atkinson et al., 2007. 42

Table 3 Factors that facilitate and provide challenges to multi-agency working adapted from Atkinson et al., 2007. 53

Table 4 Barriers and facilitators to multi-agency working from the review of literature. 54

Table 5 Common risk factors cited by researchers (Gutman et al., 2010; Corcoran and Casebolt, 2004; Statham, 2004; Orthner et al., 2004; Waller, 2001; Masten and Coatsworth, 1998; Silliman, 1998; Smith and Carlson, 1997; Fraser 1997; and Grotberg, 1995). 85

Table 6 Common protective factors cited by researchers (Stein, 2005; Masten, 2001; Luthar & Cicchetti, 2000; Masten et al., 1990; Garmezy, 1988, 1973; Rutter, 1987; Werner, 1990). 87

Table 7 Method of data collection and what sources used. 103

Table 8 Practitioners undertaking questionnaires with case study children. 119

Table 9 Children at risk of poor outcomes. 131

Table 10 Example of coding systems used with the data collected. 132

Table 11 How professionals identify children at risk of poor educational outcomes. 175

Table 12 Specific indicators used by the professionals for children considered to be at risk of poor outcomes. 177

Table 13 The different agencies the professionals specified that they regularly worked with. 189

Table 14 Specific language used by professionals at interview 197

Table 15 How practitioners build resilience with case study pupils. 232

Table 16 Commonly identified risk factors from the review of literature compared to the research findings. 260

Table 17 Common protective factors from the review of literature (e.g. Gutman et al., 2010; Stein, 2005; Masten and Coatsworth, 1998; Fraser, 1997; Williams, 2001) compared to factors identified by at least two professionals within the field research undertaken. 262
ABBREVIATIONS

ADHD: Attention deficit hyperactivity disorder is a developmental disorder. It is characterised by the co-existence of attention problems and hyperactivity.

ASD: The autism spectrum or autistic spectrum describes a range of conditions classified as pervasive developmental disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Pervasive developmental disorders include autism, asperger syndrome, pervasive developmental disorder not otherwise specified (PDD-NOS).

BERA: British Educational Research Association

CP: Child Protection

CBT: Cognitive behavioural therapy - A talking therapy that can help one to manage emotional problems by changing the way one thinks and behaves.

DfES: Department for Education and Skills (now known as the Department for Education)

EP: Educational Psychologist

ECM: Every Child Matters

GCSE: General Certificate of Secondary Education

NHSP: The National Healthy Schools Programme is a joint project between health and education to improve health, raise pupil achievement, and improve social inclusion.

ICT: Information Communication Technology

LA: Local Authority

LAC: Looked After Child

Ofsted: The Office for Standards in Education – regulates standards of teaching in school

PCT: Primary Care Trust – part of the National Health Service

SATs: Standard Assessment Tests given to pupils at the end of year 2 and 6

SEN: Special Educational Needs

SSLP: Sure Start Local Programme

Statement: Statement of SEN is a formal document detailing a child's learning difficulties and the help that will be given.

TA: Teaching Assistant

Webster Stratton: The Webster-Stratton Incredible Years is a parent /carer training programme for improving the behaviour of children aged 12 years and under. It is targeted at parents /carers of children displaying behavioural difficulties.

Abstract

The Laming Report into the death of Victoria Climbie highlighted the inadequacies of inter agency collaboration and communication and subsequently led to the Every Child Matters Green Paper 2003 and Children Act 2004. Collaboration and partnership working in children’s services became central to England Labour Government thinking and policy. Children and families were to be at the heart of care planning with agencies working effectively together to ensure a coordinated and integrated service delivery. However, the complexities of multi-agency working have tended to impede effective collaboration, often leading to dysfunction and lack of coherent intervention strategies.

The thesis examines the cultural and organisational difficulties of multi-agency work, and specifically, the need for a common language and framework upon which professionals can build a unified understanding of an individual in order to implement coordinated and coherent interventions.

The thesis explores the concept of ‘risk,’ accompanied by the linked notion of ‘resilience,’ and considers the use of a risk and resilience framework as a possible way forward for professionals, from different agencies, to better understand a child’s needs, to compare views, share information and allow a unified strategy for intervention.

The research is based on case study design and uses qualitative methodology. Findings are generated through analysis of 16 interviews, 29 questionnaires undertaken with professionals across the key children’s services associated with an inner city school, five pupil case studies and one field trial. The roles of professionals involved within the research were education and clinical psychology and psychiatry; Headteachers, teachers and non teaching staff; school nurse, counsellor and therapists; Looked After Children, family intervention, and social care practitioners.

The research adds to the literature on multi-agency working and offers evidence that, despite conceptual differences amongst key children’s services professionals, there is a degree of overlap and complementary understanding. The study contributes to current research and theoretical knowledge through the exploration of a conceptual framework (the risk and resilience framework) which, when used within a school setting, appeared to unite professionals in a shared understanding of a child and proved to be productive. The key finding is that although professionals may see children differently, there is overlap and if one finds the right catalyst one can produce a shared understanding and effective educational outcomes for children.
DECLARATION

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**Chapter 1: Introduction**

**An overview**

This thesis explores the cultural and organisational difficulties of multi-agency working within an educational setting and specifically the need for a common language and framework upon which professionals can build a unified understanding of an individual in order to implement coordinated and coherent interventions. The context in which the study took place was a school in an urban area that was populated by students who came from disadvantaged backgrounds. The study examines the concepts of ‘risk,’ and ‘resilience,’ and considers the use of a risk and resilience framework as a possible way forward for professionals, from different agencies across the key children’s services, to understand a child’s needs, to compare views, share information and allow a unified strategy for intervention.

This chapter provides an introduction to the research study. It considers the context and historical background of the research and establishes my own position with regard to the research undertaken. Issues arising from multi-agency work, including the different conceptualisations that professionals hold with regard to children, are briefly discussed, as is the rationale for the use of the risk and resilience framework within the study.

The aim of the study is considered and the research questions identified. Thereafter, the chapter gives an outline of the subsequent chapters within the thesis, concluding with a brief research summary.

Throughout the research, the term multi-agency has been used to denote joint working or collaborative practice across the service providers of, education, health and social care.
Background to this research

The Laming Report (Laming, 2003) into the death of Victoria Climbie highlighted the inadequacies of multi-agency collaboration and communication and subsequently led to the *Every Child Matters: Green Paper 2003* and *Children Act 2004*. Collaboration and partnership working in children’s services became central to government thinking and policy as exemplified within; Integrated Children’s Services - aimed at bringing children’s services closer together and ensuring greater cooperation between agencies in relation to providing services to children and families (DfES, 2004a); Sure Start Children’s Centres which were to secure integrated early childhood services (DfES, 2006a; DfES, 2009); and the Common Assessment Framework - an attempt to, “introduce a non bureaucratic, common method of assessing the needs of children and young people that can be used by the whole children’s workforce” (DfES, 2004a, section 2.3).

Children and families were now at the heart of care planning, with agencies working together to ensure coordinated and integrated delivery.

With the death of Baby P in August 2007, the Government requested an urgent progress report with regard to effective safeguarding arrangements following the reforms introduced in the wake of the Climbie case, namely *The Laming Review* (Laming, 2009). One of the key aspects of this report was an assessment of the progress made and the identification of barriers to effective implementation of multi-agency working. While recognising much had been done through effective policies and practices such as *Every Child Matters 2003* and the inter agency guidance *Working Together to Safeguard Children 2006*, the *Laming Review* nonetheless called for further action to be taken:

One of the main challenges is to ensure that leaders of local services effectively translate policy, legislation and guidance into day-to-day practice on the front-line of every service (2009, p.4).
And that:

Much more needs to be done to ensure that the services are as effective as possible at working together to achieve positive outcomes for children (ibid, p.9).

The importance of effective multi-agency collaboration is indisputable and schools are central to this process. However, multi-agency working is often complex and impeded due to incongruence of goals, perspectives and priorities (Warmington, 2004). Issues of inter professional understanding of roles, responsibilities, approaches, cultures and theoretical conceptualisations all impact on effective collaboration (see Todd, 2007, Robinson and Cottrell, 2005, and Hudson, 2002).

The complexities of multi-agency collaboration and understanding children in a shared way are explored within this study. The barriers and facilitating factors are discussed within a broad context and, to a certain extent, in a more detailed perspective within the context of a case study secondary school.

The researcher and reasons for the study

When this study was undertaken, I was a Deputy Headteacher in an inner city 11-16 comprehensive school. I had responsibility for Transition, Inclusion and acted as the school’s Special Educational Needs Coordinator. I was responsible for liaising with professionals across the key children’s services of education, health and social care. My role was to identify vulnerable children, track and monitor pupils in terms of attendance, behaviour, exclusion and attainment. I commissioned and coordinated interventions for pupils, organised and attended multi-agency reviews and oversaw the work of external and internal inclusion staff.
It was through this inclusion role that I became aware that certain children experiencing significant personal difficulties, as well as socioeconomic and cultural disadvantage, nonetheless did well, often achieving very positive educational outcomes. Others, however, did not do so.

The role had also highlighted issues with regard effective multi-agency relationships and collaboration. The tensions between school and external professionals often reduced the effectiveness of collaborative practice and at times, impeded positive educational outcomes for pupils. The difficulties of effective multi-agency working tended to be around the following aspects: organisation of the school day and ‘academic year’ compared to professionals who were not tied to the school academic calendar (e.g. the differences of times when professionals were available to meet or speak with were often inconvenient) leading to frustration and miscommunications; difficulties with sharing confidential information; lack of understanding of the different thresholds for external interventions with particular reference to social care and health professionals, such as the social worker and clinical psychologists; lack of understanding of roles, responsibilities and particular needs of professionals across the key agencies; and lack of understanding of professional cultures and respective corporate targets which often determined interventions. Further, there was a lack of understanding and, at times, a degree of criticism with regard to interventions undertaken. Ultimately, key children’s service delivery was often dependent upon individual relationships rather than on a common quality of service.

It was also clear that professionals had their own understandings of children and worked within their own, and often dominant, organisational cultures. For instance, in the many case conferences or review meetings held about children, terms used were often jargonistic or technical, leaving teaching assistants and support workers, in particular, not fully understanding conversations, as well as
causing frustration for parents who could not always understand what was being said or recommended. Thus, when multi-agency collaboration was required, misunderstandings and lack of real communication often prevailed, leading to professional frustrations and difficulties.

I also found that professionals I worked with often protected their own agendas, due to the demands that were placed on them by their own organisations, as opposed to responding to the actual need of the individual child that they were faced with. Furthermore, they tended to see children within a very narrow lens - that of their own professional culture rather than within a common framework. This often led to frustration and impacted adversely upon professional relationships and, ultimately, on the children that all professionals were trying to support effectively. This was particularly evident with one pupil I was currently working with in my school; the differences in understanding the needs of this pupil, involving school, clinical, educational psychology and psychiatry professionals, led to no real agreement about how to meet the child’s individual needs.

Furthermore, the frustration professionals had were often detected in minutes of meetings. For example, one of the health meetings minutes I had access to stated that:

the child has gone through mainstream primary school without the extent of their difficulties having been fully recognized or understood.

As an Inclusion Deputy Headteacher, I wanted to find a way of bringing professionals from different agencies together in a more positive way in order to ensure better educational outcomes for particularly vulnerable children. This in essence meant finding common ways of identifying and supporting the most vulnerable children at risk of poor educational outcomes; talking about them in a
way that all professionals understood and putting in place effective interventions in a coordinated and collaborative way. The different ways of understanding children needed to have a more unified approach if children were to get the best out of the professionals working with them. Further, I needed to find a way to enhance relationships between the professionals, as the issues were long-standing within the school I worked, as well as in two previous institutions where I had a similar role. Additionally, the problems experienced were often discussed at various SENCO network meetings and with professionals from key children’s services within the community at the centre of this research.

The complexities arising from multi-agency work and the different conceptualisations that professionals hold about children within a school setting were thus clearly evident. It was for these reasons, therefore, that I became interested in exploring a way forward for professionals across the key children’s service providers to have a common framework in which they can all understand children as well as a common language in which to discuss them.

Thus, this study examines the concept of ‘risk,’ accompanied by the linked notion of ‘resilience,’ and considers the use of a risk and resilience framework as a possible way forward for professionals across the key children’s agencies to work collaboratively in order to improve educational outcomes of children. Ultimately, I wanted to find a way to improve educational outcomes for the pupils I worked with - often the most vulnerable children and families within the school I served.

**Conceptual frameworks**

The lack of a framework that unites professionals across the key children’s services pertaining to education, health and social care in a shared understanding of need, and one that addresses deep seated cultural and assumptional differences is explored within this study. Professionals working with children across the key
children’s services often have conceptual understandings of children that can be diverse. Different professionals have different frameworks which are driven through a pathological or social focus. For example, conceptualisations may be built on psychosocial or cognitive behavioural models, or on a diagnostic or deficit models (Corcoran and Casebolt, 2004).

Professionals from social care tend to have a very person centred approach and ideas or strategies are constructed around such approaches. Social care constructs are found in the inter relationships concerning the individual, their family, social networks and the wider community (Northern & Kurland, 2001, p. 49). In health however, the dominance of the medical model emphasises the notion of disease and pathology, i.e. an illness requiring treatment (Crinson, 2007). There are many different ways of viewing children, through the concept of need, for example, or well being. Different conceptualisations held can lead to dysfunction in a system aimed at support, and lack of coherence.

Concepts not only relate to theory but also embrace a set of values. The values that professionals have can be very different and can lead them to work in accordance to their own understandings rather than a shared understanding. This can lead to particular difficulties for multi-agency working. Robinson and Cottrell (2005) found that the different conceptions that professionals had gave rise to different explanation for a particular behaviour and thus the respective intervention. They cite the example of a multi-agency team’s conceptualisation of offending behaviour which included social and psychiatric/psychological models. They concluded:

\[\text{differences in beliefs among professionals conveyed differing implications about interventions with offenders. .... attitude factors, attributable to differences of professional culture, hinder collaboration (2005, pp.551-2).}\]
Furthermore, professionals across the key children’s services often use their own specific language:

Practitioners from different disciplines are not routinely expected to justify the conceptual base of their actions or interactions with clients in single agency settings. In a multi-agency setting team differences potentially "collide" as boundaries around specialisms are broken down. At this point, implicit knowledge must often be made explicit. Professionals have to find a common language to make knowledge accessible to their colleagues from other disciplines (ibid, 2005, p.549).

Children are thus understood, talked about and responded to in different ways. The different values and understandings that professionals have can impact on effective multi-agency working, often resulting in poor service delivery and ineffective professional relationships. Such frameworks are discipline specific and not necessarily understood by external collaborating professionals. They do not ensure that professionals from different backgrounds will understand children’s difficulties in the same way, identify the same children as in need of intervention, or see the same interventions as appropriate. Theoretical understandings can impact on interventions and ultimately on the actual outcomes for children. Having a common framework is important and the concept of a risk and resilience framework is thus explored.

**Risk and resilience**

Factors, for example poverty, familial dysfunction and adverse living conditions are shown to significantly increase risk levels within children so that their life chances are diminished in terms of education, income, health and social contribution (Schoon et al., 2004; Swadener and Lubeck, 1995). These factors may be considered as risks and may be defined as; “influences, occurring at any systemic level, that threaten positive adaptational outcomes” (Waller, 2001, p.292).
Some children, however, despite considerable difficulties and disadvantage succeed in life. Such children may be regarded as being resilient. Resilience may be defined as:

The inherent and nurtured capacity of individuals to deal with life’s stresses in ways that enable them to lead healthy and fulfilled lives (Howard and Johnston, 1999, p.3).

Thus, in essence, the risk and resilience framework:

- considers the balance of risk (forces contributing to a problem condition) and protective (internal and external resources for the protection against risk) factors that interact to determine an individual’s ability to function adaptively despite stressful life events (Corcoran and Casebolt, 2004, p.212).

**A rationale for the use of the risk and resilience framework within the study**

The study explores the use of a risk and resilience framework as a possible way forward for professionals from different agencies to understand and discuss a child’s needs in order to execute an effective and unified strategy for intervention. The framework may be considered ‘neutral’, as it is one that is not used specifically by education, health or social care professionals, although it does have advocates in all sectors.

The risk and resilience framework is a conceptual framework that is empirically validated (Stein, 2005; Corcoran & Casebolt, 2004; Garmezy, 1993; Rutter, 1987; Werner and Smith, 1982). It offers a balanced view of systems in that it looks at both risk and strength, namely protective factors, and recognises the “complexity
of individuals and the systems in which they are nested” (Casebolt and Corcoran, 2004, p.213).

Originally developed in the disciplines of psychology and education for the understanding of individual behaviour, the concept of risk and resilience has more recently emerged as a construct for conceptualising health and social problems (Schoon, 2005, 2002; Corcoran and Casebolt, 2004; Fraser et al., 1999; Gibbs and Gambrill, 1999; Howard and Jenson, 1999). Thus, the risk and resilience framework may be considered as one that professionals across health, education and social care may find of use.

Although the risk and resilience framework has remained theoretically conceptualised rather than used as a tool for professional practitioners (Corcoran and Casebolt, 2004), this study considers if the framework can support collaborative practice on an equitable basis, facilitate a shared understanding and possibly a shared strategy. Within the study, the framework is utilised within a practical ‘real-life’ context to see if it allows professionals to plan together through the use of a common language and utilise own area of expertise to impact on a case study child.

The study also recognises that the risk and resilience framework is complex, and one which, as Howard et al., (1999) note, is not always used with great precision nor carries a guarantee that professionals will agree with one another’s understanding of risk and resilience; nor that their understandings will correspond with what is known from the research literature; nor that they will correspond with what children themselves feel to be the risks in their lives. Critics may argue that prospects for co-ordinated interventions may therefore be remote, and/or such interventions may fail to target effectively the actual risks to which children are subject. Further, that there is great variability in how risk and resilience interact to determine outcomes, e.g. by time, context, etc.
Advocates, such as Jenson and Fraser (2011), suggest that through using the framework, professionals are able to surface their own assumptions without jargon thus leading to greater clarity of shared conceptualisations and actions. To understand the difficulties that children face and to inform subsequent intervention plans, practitioners have to address both the risk and the ways of developing future protection from presenting risks. Furthermore, the potential of the framework is such that it could help support and inform social policy (Fraser, Richman and Galinsky, 1999; Howard & Jenson, 1999). Indeed, one may argue that the significance of the framework perhaps rests in potential policy impact:

a shift of emphasis from crisis intervention to primary prevention before serious maladjustment has already manifested itself (Schoon and Bynner, 2003, p.26).

Clearly, it is important to understand how professionals working with children in disadvantaged circumstances understand the risks to which those children are subject, the extent to which they share common understandings, and the implications of those common or different understandings for the possibility of co-ordinated action. Indeed, as Little (2003) states:

The starting point should always be an analysis of risk and protective factors to give a prognosis of the child’s future development. This analysis can be translated into a statement of the child’s unmet needs. This will provide a platform for decisions about how and when to intervene. Whatever the circumstances, it makes sense to foster the child’s inherent strengths and resilience, and where impairment exists to bolster their coping strategies (2003, p.22).
The research questions

This research is concerned with the extent to which professionals, working with school-age children in an urban context, share common understandings of the risks for poor educational outcomes to which those children are subject. It seeks to answer the following questions:

1. What understandings of risks for poor educational outcomes do professionals from different backgrounds, but working with the same children, have?

2. How congruent with each other are those different understandings?

3. How congruent are they with understandings of risk in the research literature?

4. How do these professional understandings shape the interventions with children that different professionals propose, and what are the implications for the possibility of co-ordinated and effective interventions?

5. Is the risk and resilience framework a viable one to utilise by professionals from across the key children’s services, in order to develop a shared understanding of the child and thus ensure coordinated and effective interventions?

Overview of the thesis

The thesis is structured in the following way:

Chapter 2: Review of Literature
Chapter 2 looks at the historical background, and context, for multi-agency working in relation to Labour Government Policy (England) (2003 – 2010) and the reason for ensuring more effective service delivery. The impact on government policy of the death of Victoria Climbie and subsequently that of Baby P are considered within the chapter. Policy documents such as *Every Child Matters* 2003; *Next Steps* 2004 and *Working Together to Safeguard Children* 2006 are referenced and their impact on Local Government considered. *The Protection of Children in England: A Progress Report* (Laming, 2009) indicated that earlier reforms had not gone far enough and that issues abounded with effective inter agency collaboration resulting in Laming stating that there were still:

significant problems in the day to day reality of working together across organisational boundaries and cultures (2009, p.10).

The rationale of multi-agency working is explored and, in particular, the organisational and cultural facilitators and barriers to multi-agency working examined. A brief analysis of the various conceptual frameworks that are utilised amongst the key service providers, such as those of ‘psychosocial’ and ‘well being,’ is given.

The review of literature identifies the need for a common language and framework in order for professionals to develop a shared understanding of children and collaborative strategy for intervention for improved life outcomes. The risk and resilience framework is thus discussed as a means of conceptualising children’s difficulties across the key children’s services and to ascertain if it may potentially serve to improve the effectiveness of multi-agency working.

The review of literature provides a framework for the researcher to understand, explain and make informed sense of the data collected. It establishes:
i. key cultural, structural and organisational factors relating to multi-agency collaboration;

ii. common professional misconceptions across the key children’s services;

iii. common risk factors and risk indicators within an urban environment;

iv. definitions and understanding of risk within an educational context; and

v. a definition of risk and resilience.

The chapter seeks to how explain how risk and resilience may offer a solid framework which professionals, across the key children’s services, can use to inform their practice with children who are likely to experience poor educational outcomes.

Chapter 3: Research design and methodology

The research is case study design and focuses on an inner city secondary school where I teach. Professionals who work at the school or who are associated with the school were interviewed or asked to complete a questionnaire for purpose of data collection. Particularly vulnerable children, upon transition, were identified and, from those, five children were then selected as case study examples.

Qualitative methodology used within the research is outlined in this chapter and includes; a review of literature (in terms of allowing the researcher to understand, explain and make informed sense of the data collected); secondary analysis of data; use of semi structured interviews; use of questionnaires; five child case studies and a field trial focussed on the specific use of the risk and resilience framework with a particular child.

Chapter 4: Research Findings
This chapter is divided into four main parts.

**Stage 1:** The findings that arose from the interviews undertaken with professionals from across the key children’s services are discussed in relation to their understanding of:

i. children at risk of poor educational outcomes; the risks that children face within the specific case study community and the major concerns / or risks for children in their care.

ii. how professionals identify children at risk of poor educational outcomes.

iii. the term resilience and the factors that enabled a child to become resilient to the difficulties / problems encountered.

iv. how the different professions build / promote resilience within children.

v. the agencies that professionals engage with in regard to children at risk of poor educational outcomes.

Themes emerging from the data are also discussed, including evidence of professional conceptualisations; lack of a common language; and critical responses made towards respective service providers.

**Stage 2:** The findings from the school documentation, questionnaires and child case studies are focussed on. The data was analysed, organised and reported with regard to the following aspects: Section A focuses on individual pupil case studies; Section B analyses the practitioners’ general understanding of risks and of resilience; Section C considers the coordination and coherence of provision; Section D analyses multi-agency working in a practical setting. This is then followed by an overall summary of findings for this stage of data analysis.
**Stage 3:** This focuses on a field trial regarding a particular child, highlighted at risk of poor educational outcomes and how the professionals involved utilised the risk and resilience framework to improve that pupil’s outcomes. The section is subdivided into the following aspects: i. context; ii. identified risk and protective factors; iii. common concerns and priorities; and iv. a shared strategy and agreed actions; v. conclusion.

Findings from this field trial are shared with regard to the utilisation of the risk and resilience framework and some of the inherent difficulties of multi-agency working experienced.

**Stage 4:** This section gives a brief summary of the overall findings relating to the empirical review of literature focusing on multi-agency work; risk and protective factors, and resilience.

**Chapter 5: Conclusion and Recommendations**

The final chapter revisits the purpose of the study and considers the thesis’s contribution to scholarly knowledge in relation to multi-agency collaboration, professional conceptualisation and how a common framework can be productive. The chapter revisits the research questions and attempts to answer them. The limitations to the research are considered and recommendations are presented. The chapter considers in light of the findings presented in the preceding chapter, if the risk and resilience framework is a useful way of allowing professionals to go beyond separate conceptualisation and to open effective dialogue between them, building on what they have in common to achieve better educational outcomes for children. A list of references used throughout the study is given at the end of the thesis, as are the appendices.
Summary
The research takes forward theoretical knowledge gained through the focus on multi-agency working within an urban school, populated by students who came from disadvantaged backgrounds. The research extends knowledge with regard to professional conceptualisations and the role these play in facilitating/hindering collaboration. The study makes a practical contribution to research through its exploration of the risk and resilience framework within a specific child case context.

The research undertaken seeks to find a more effective way of multi-agency working in order to improve educational outcomes of vulnerable children. The context and rationale of multi-agency working is discussed as are its barriers and facilitators. The conceptualisation of children that the key children’s services professionals hold are considered, as is the need for a common language amongst service providers in order to ensure clarity, a better understanding of children and unity of understanding for effective and coherent interventions.

The research involves key professionals associated with the case study school, and working with pupils, from across the key children’s service providers. Their conceptual perceptions of pupils are analysed using qualitative methodology.

The study suggests that using a common framework and a common language is important in enabling professionals to talk more effectively to each other and coordinate actions coherently. It considers whether the risk and resilience framework can be a unifying framework to support effective multi-agency working in order to ensure collaborative understanding of children across the key children’s services of education, health and social care. The advantages and disadvantages of this framework are thus explored within the course of the findings.
Chapter 2: Review of Literature

An overview

This chapter traces the development of multi-agency collaboration through key United Kingdom (specifically English) Labour Government policies implemented in the wake of the death of Victoria Climbie (25th February 2000) and, later, that of Baby P (3rd August 2007). The history, rationale and evaluations of multi-agency working are briefly reviewed as are the barriers and facilitators to effective collaboration. The cultural and organizational difficulties, including problems associated with professional conceptualisations and terminology, are examined alongside considerations of what might be done to enable professionals across the key children’s services to work more effectively together.

The chapter considers that in order to coordinate appropriate action, professionals may need a common language and a shared framework to understand the child better and improve educational outcomes. It is proposed that the professionally neutral risk and resilience framework is possibly an effective way for professionals across education, health and social care to work collaboratively in order to address the needs of children at risk of poor educational outcomes. The notion that the risk and resilience framework can be used to conceptualise problems and plan appropriate provision across the key children’s services is thus explored.

Introduction

The concept of collaboration and partnership working in children’s services was pivotal to the Labour Government’s philosophy and policy. Warmington (2004) refers to its ‘totemic status’ within the then current UK social policy, with the prime objective to put children and their families at the centre of service planning with agencies working collaboratively around them to deliver services efficiently and effectively to keep pupils safe, healthy and improve educational outcomes.
Collaboration between the key children’s services as a government priority has been evident in various reports and policy documents, both under Conservative and Labour Governments, from the 1970s onwards. For example, The Warnock Report (HMSO, 1978) called for a closer working relationship between the professionals across the services concerned with children. Warnock called the communication between professionals as inadequate and reported:

It was widely argued in the evidence submitted to us that information is often not shared between doctors, nurses, psychologists, teachers and social workers, and that in the interests of individual children it should be (1978, p. 295).

Warnock recognized that development of such relationships would take time as it depended upon establishing trust between the professionals and understanding of each other’s function (1978, p. 295). A decade or so later, in the Children Act 1989, one of the main themes was to encourage far greater cooperation between organisations responsible for children. The recognition that partnership working between key children’s services were essential to safeguard children were implicit in various subsequent legislation such as the Education Act 1996; Health Act 1997; and Special Educational Needs Code of Practice 2001.

Clearly, though not necessarily surprisingly, legislation itself is not enough to ensure the envisioned delivery of integrated services for the benefit of service users. Indeed, in response to the Laming Report 2003, the then Secretary of State for Health, Alan Milburn, appears to summarise the difficulties:

Sound legislative policy and guidance is frankly useless unless we can be sure that it is implemented effectively and consistently. Victoria needed services that worked together. Instead, the report says there was confusion and conflict. Down the years, inquiry after inquiry has called for better communication and better co-ordination. Neither exhortation nor legislation has proven adequate (Guardian, 2003).
From 1997 – 2010, multi-agency working was a key Labour Government priority in England and there was a drive to ensure effective and efficient delivery of child services and support to the family, yet multi-agency collaboration and practice has not been entirely successful. The Green Paper Every Child Matters 2003 was perhaps the most significant driving force for service integration. Children’s services were restructured to ensure effective and collaborative integration of service delivery, with children and families at the heart of key government policies.

Laming’s recommendations were a response to an extreme situation but the underlying vision of the then Labour Government was to ensure more integrated service delivery. Multi-agency working was given a huge push through the various policy initiatives amongst claims of efficacy and efficiency, but it did not always work. Professionals, with their own language and body of knowledge and different ways of thinking, found the move towards service integration difficult to achieve even within this statutory framework, driven by central government (Sloper, 2004).

In recent years, there has been consensus within the literature with regard to the value and importance of multi-agency collaboration but there tends to be a focus and emphasis on the inherent problems or barriers to effective implementation (Barr & Ross, 2006; Salmon & Rapport, 2004, Stead et al., 2004;). The literature often emphasises the inherent difficulties of multi-agency process rather that the impact on outcomes for children and families. It also indicates that there are immense complexities underpinning core children’s service relationships, especially with regard to ethos, practice and philosophies which are not easily resolvable. Underpinning the difficulties perceived amongst professionals, alongside culture, organisational and ethos, is a lack of common language which adds to
misconceptions and professional distrust (Watson, 2006; Bertram et al., 2002). Indeed, as previously cited, Warnock (HMSO, 1978) stated that the development of trust would indeed take time and the difficulties recognised by Laming (2003) appear to continue to this day:

It is evident that legislation alone is unlikely to bring about the step changes necessary to deliver the positive outcomes for young people anticipated in the Children’s Plan. To be most effective, integrated services and multi-agency teams require deep rooted cultural change to ensure that different professional groups work together effectively across various organisational boundaries and fault lines. The use of different forms of language to speak about young people symbolised strong demarcations of professional identity and orientation (Harris and Allen, 2011, pp. 405-409).

This chapter thus looks to ascertain if the alternative and ‘neutral’ conceptual framework of risk and resilience might be useful to consider as a way forward for a more effective basis on which to secure a commonality of understanding to ensure effective multi-agency collaboration and intervention. The framework maybe considered ‘neutral’ - one that is not owned or used specifically by education, health or social care professionals, although it has advocates in all sectors (Croom and Proctor, 2005; Corcoran and Casebolt; 2004; Noam and Hermann, 2002).

The risk and resilience framework allows for a ‘common language’, collaborative practice on an equitable basis and a shared understanding. Thus, it could help to facilitate a shared strategy in response to meeting the needs of the child (Corcoran & Casebolt, 2004) and assist the trajectory for positive outcomes through effective multi professional collaboration and improved dialogue.
Background Policy

The Labour Government inquiry into the tragic death of the child Victoria Climbie, undertaken by Lord Laming in 2000, highlighted the immense inadequacies of multi-agency collaboration and communication that currently existed within key child and family core services. Laming stated that Victoria Climbie’s suffering and subsequent death “was a gross failure of the system,” (Laming Report, 2003, section 1.18) and that “failure to protect her was the result of widespread organisational malaise” (ibid, section 1.21).

Laming called for an improvement in the quality of the management and leadership of key services within a multi disciplinary framework and “a fundamental change in the way that services to support children and families are organised and managed” (ibid, section 1.34).

Laming made several recommendations to strengthen the safeguarding of children including the establishment of a Children and Families Board at the heart of government, a National Agency for Children and Families, a Management Board for Services to Children and Families and the appointment of a Director of Children and Family Services at local level. Recommendation 6 of the Laming Report cited that each local authority with social services responsibilities must establish a Committee of Members for Children and ensure properly coordination of the services to children and families and effective management of the inter-agency work (see paragraph 17.97).

In essence, Laming highlighted the need for urgent action which ultimately led to radical steps in pursuit of integrated, effective and coherent service delivery for the benefit of children, young people and their families.

The new Labour Government’s response to the Laming report was set out in several key documents, for example, Every Child Matters 2003, Children Act 2004,
Every Child Matters: Next Steps 2004; and Every Child Matters: Change for Children 2004. Together these set out major changes in the way key children services were organised and delivered.

The deaths of Climbie, Colwell, Wright and Walker, cited in the Green Paper Every Child Matters, 2003, were all due to the one common thread of;

failure to intervene due to poor coordination, share information, lack of accountability, inadequate staffing, poor management and lack of training (DfES, 2003, p.5).

The Green Paper stressed the importance of early intervention and accountability and called for the integration of schools, health and social care services around the needs of the child through an extended school model: “offering the community and their pupils a range of services that go beyond their core educational offer” (section 2.20). It promoted the concept of the full service extended schools that offered childcare, study support, health and social care, sports and arts facilities, parenting support and ICT access (section 2.21). The Paper further called for integrating professionals through multi-disciplinary teams in order to identify those children at risk and to ensure services of education, health and social care are integrated around their needs and not those of the providers (sections 4 and 4.25). Section 4.25 of the Paper called for multi disciplinary teams that work together, without losing the advantage of those professionals’ individual specialisms.


We want to put children at the heart of our policies, and to organise services around their needs. Radical reform is needed to break down organisational boundaries. The Government’s aim is that there should be one person in
charge locally and nationally with the responsibility for improving children’s lives. Key services for children should be integrated within a single organisational focus at both levels (DfES, 2003, p.9).

The Children Act 2004 further ensured that all agencies involved in the universal framework of services supporting children work together in a coordinated and uniform way (Reid, 2005). The Act required Local Authorities to put in place a Director of Children’s Services and Lead Member to be responsible for, as a minimum, education and children’s social service functions.

Thus, the aforementioned Acts essentially laid out the Labour Government’s vision for the integration of key services in a single child-focused organisation to deliver improved outcomes for children and young people against the Every Child Matters framework of being healthy, staying safe, enjoying and achieving, making a positive contribution, and achieving economic well-being; better outcomes secured by services working together more effectively.

Section 10 of Every Child Matters: Change for Children, 2004, established the duty on the Local Authority to ‘promote co-operation between each of the authority’s relevant partners’ (Part 2 section 10, 2004).

Guidance within Working Together to Safeguard Children 2006 reflected development in legislation, policy and practice and replaced the 1999 version. The document emphasised the importance of the creation of a Children’s Trust, the establishment of Local Safeguarding and the ‘duty of on all agencies to make arrangements to safeguard and promote the welfare of children’ (2006, p.11).

The document states:

a shared responsibility and the need for effective joint working between agencies and professionals that have different roles and expertise are
required if children are to be protected from harm and their welfare promoted. In order to achieve this joint working there have to be constructed relationships between individual practitioners, promoted and supported by: the commitment of senior managers to safeguard and promote the welfare of children; and clear lines of accountability (2006, p.12).

There was an emphasis too on the importance of inter agency training as;

a highly effective way of promoting a common and shared understanding of the respective roles and responsibilities of different professionals and contributes to effective working relations as well as to secure improved outcomes (2006, section 4.2, p.96).

By 2008, all Local Authorities were expected to ensure that their Children’s Trust arrangements had integrated front-line delivery, integrated processes, integrated strategy, and inter-agency governance. The conglomeration of new legislation, guidance, structures and policy initiatives were all geared to improve child well being and life outcomes.

Children’s Trusts were tasked to develop the local strategy for improving children’s lives through more effective delivery of services through effective partnership collaboration including Primary Care Trusts. One essential feature of the Children’s Trust was effective joint working sustained by a shared language and shared processes.

Collaboration and partnership working also underpinned Sure Start, aimed to improve life outcomes of those most vulnerable from poor backgrounds. Thus, children and families came to be at the heart of care planning with agencies supposedly working together to ensure coordinated and integrated delivery.

Reasons for multi-agency working were considered as being in the best interest of the child and family, and that joined up and coordinated integrated services are effective in the prevention of exclusion and child abuse, and supported wider aspects of inclusion and addressed social exclusion issues (Milbourne et al., 2003).
For children living in special circumstances, such as domestic violence, drugs, alcohol, mental health, etc, the most effective way of meeting their needs was through a holistic multi-agency approach as opposed to agency compartmentalisation (Statham, 2004).

An integrated service was meant to be a way forward to ending service duplication, ineffectiveness, counterproductive actions and contradictory messages. Hartley (2009) refers to the increasing ‘trend’ for collaboration within the public service, (relating to education, health and social care), the preponderance of ‘multi’ and ‘inter’ agency configurations and the attempt to dissolve ‘once-impermeable professional boundaries’ (p.127). Hartley (2009) suggests that service delivery was part of the growing ‘personalisation’ process that was characterizing public services; the user was the customer, not a patient or mere service user – inter agency collaboration being the only way in which the personalized needs of the individual were to be met. Part of Hartley’s argument was drawn from the Prime Minister’s Strategy Unit 2006 which outlined Labour’s public reform from top down management, choice and voice of citizens and competitive provision. Hartley states that market, as opposed to bureaucratic, forces characterised public services in order to ensure personalisation of delivery. In essence, the new model of public services “comprises a mutually supportive amalgamation of bureaucracy, markets and inter agency working” (p.18.).

Ultimately, however, the Labour Government was commended by Laming (2009) for the legislation and guidance put in to safeguard children:

Laming stated:

Every Child Matters clearly has the support of professionals, across all of the services, who work with children and young people. The inter agency guidance Working Together to Safeguard Children provides a sound framework for professionals to protect children and promote their welfare. New models for early intervention developed nationally and
delivered locally through extended schools and Sure Start Children’s Centres have established a solid foundation on which to build more imaginative and flexible responses to the needs of children and families (Laming, 2009, pp. 3-4).

However, despite government policies and endorsements through legislation pertaining to multi or inter agency working and collaboration, and aspects of DCSF and Strategy Unit officialdom, there remained significant problems and difficulties in its implementation on a wide scale. Indeed, as Dyson et al., (2009) state:

multi-agency working is not as straightforwardly rational as repeated government exhortations might make it appear ... and that the pursuit of multi-agency collaboration is more complex than a rational perspective might seem to suggest (p.7).

Further, the continued failure to safeguard children is still very evident. The death of Baby P in August 2007 resulted in the Rt Hon Ed Balls MP commissioning a report by Lord Laming as to the progress of the implementation of effective safeguarding arrangements. The subsequent review of children’s services revealed child protection issues in England had not had deserved priority and many of the reforms brought in after Victoria Climbie’s death in 2000 had not been properly implemented. Moreover, that there was a still a lack of communication and joined-up working between agencies.

Lord Laming stated:

challenges of working across organisational boundaries continue to pose barriers in practice, and that cooperative efforts are often the first to suffer when services and individuals are under pressure. Examples of poor practice highlighted to this report include child protection conferences where not all the services involved in a child’s life are
present or able to give a view; or where one professional disagrees with a
decision and their view is not explored in more detail; and repeated
examples of professionals not receiving feedback on referrals (2009,
section 4, p.337).

Guidelines for protecting children were thus revised and recommendations put
into effect through the updated Working Together to Safeguard Children 2010. Key
changes, for example, included the widening of the definition of children at risk,
statutory representation on the Local Safeguarding Children Boards of schools and
more specific requirements regarding training and development for inter agency
work.

It is perhaps time to review the difficulties associated with multi-agency working
and seek ways of resolution; ‘Inquiry after inquiry,’ legislative acts and policies
having made little real difference to extreme cases such as Baby P. nor to some of
the wider practices of multi-agency working.

**Multi-agency collaboration: a literature review**

A literature search was undertaken using key search terms: multi-agency, inter
disciplinary, multi disciplinary, inter professional, multi professional and inter
agency working / collaboration. The interchangeable use of such terms made
identification of relevant literature quite complex (see Appendix 1). The searches
were undertaken within the relevant fields of education, health and social care.
Databases included NetLibrary, Intute, JRUL, OVID, British Education Index,
Education: Sage Full text and PsycInfo and ERIC. Restricted and detailed searches
with regard to multi-agency working were carried out within the years 2003 –
2012. This essentially related to the restructuring of children’s services but the
search also included articles prior to 2003 that were deemed relevant and
important. The searches were mainly limited to research undertaken that undertaken within the context of the United Kingdom.1

The review of literature identified varying aspects areas and subfields of multi-agency working which become evident later and are captured in the table below.

1Table 1 The varying aspects areas and subfields of multi-agency working stemming from the review of literature

<table>
<thead>
<tr>
<th>Aspects of Multi-agency collaboration</th>
<th>Authors</th>
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<tbody>
<tr>
<td>Government policy and legislation</td>
<td>Skinner and Bell, 2007</td>
</tr>
<tr>
<td>Young people’s views of multi-agency working</td>
<td>Harris &amp; Allen, 2011</td>
</tr>
<tr>
<td>Philosophical and ethical dilemmas of multi-agency working</td>
<td>Freeman, Miller &amp; Ross, 2000 and Irvine et al., 2002</td>
</tr>
<tr>
<td>Professionals working with children</td>
<td>Todd, 2007, 2010</td>
</tr>
<tr>
<td>Complexities of multi-agency working</td>
<td>Reynolds 2007, Frost and Robinson 2007; Salmon and Rapport, 2005</td>
</tr>
<tr>
<td>Facilitators of and barriers to multi-agency working</td>
<td>Daniels et al., 2007; Leadbetter et al., 2007, Atkinson et al., 2005, Sloper 2004, Reynolds 2007, Milbourne et al., 2005, Easen, Atkins, &amp; Dyson, 2000</td>
</tr>
<tr>
<td>Professional identity and discourse</td>
<td>Bell and Allain, 2010, Robinson, Anning and Frost, 2006</td>
</tr>
<tr>
<td>The implications of different conditions of service and pay scales</td>
<td>Atkinson et al., 2001</td>
</tr>
<tr>
<td>Multi-agency definition</td>
<td>Atkinson et al., 2007, McInnes, 2007</td>
</tr>
</tbody>
</table>

1 Irvine 2002 excepted but research relevant to thesis
Joint training and professional development | Anning, 2005
---|---

**Terminology used**

Multi-agency activity takes many forms and the terminology used to describe it varies significantly. Atkinson *et al*.’s, (2007), comprehensive review of literature on multi-agency working and its implications for practice, similarly reveals the complexity of terminology, and the ‘confusing and/or conflicting nature of some of these terms’ (p.16). Such definitions are outlined in the Table 2 below, as well as later in Appendix 1, as cited in Atkinson *et al*., 2007, p14.

**Table 2 Terms of reference for multi-agency working taken from Atkinson *et al*., 2007.**

<table>
<thead>
<tr>
<th>Multi-agency working</th>
<th>Atkinson <em>et al</em>., 2002</th>
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<tbody>
<tr>
<td>Multi-agency activity</td>
<td>Kennedy <em>et al</em>., 2001</td>
</tr>
<tr>
<td>Partnerships</td>
<td>Dickson <em>et al</em>., 2004</td>
</tr>
<tr>
<td>Partnership working</td>
<td>Fox and Butler, 2004</td>
</tr>
<tr>
<td>Interprofessional collaboration</td>
<td>Harker <em>et al</em>., 2004</td>
</tr>
<tr>
<td>Interprofessional work</td>
<td>Leathard, 2003</td>
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<tr>
<td>Interprofessional consultation</td>
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<tr>
<td>Co-operative practice</td>
<td>Harker <em>et al</em>., 2004</td>
</tr>
<tr>
<td>Joint-working</td>
<td>Kennedy <em>et al</em>., 2001</td>
</tr>
<tr>
<td>Integration</td>
<td>Leathard, 2003</td>
</tr>
</tbody>
</table>
The ‘quagmire of terminology’ (Lloyd et al., 2001, p.3) through the use of interchangeable terms such as joint-working, inter-agency working, etc, is perhaps indicative of the complexity that surrounds the whole area of multi-agency working. Warmington (2004) refers to “the plethora of terminology to describe the collaborative approaches” (p.3) and concepts relating to multi-agency working (Percy-Smith, 2005). Terms such as multi-agency, multi disciplinary and inter agency are often used without clarification of actual meaning even within Government documentation, (Soan, 2006, citing Every Child Matters : Change for children, 2004). These terms are all sporadically utilised to describe ways in which health, social care and education work together (Soan, 2006).

Different terms can be confusing due to the different connotations associated with them. Harker (2004), for example, refers to inter-professional work in order to acknowledge the emerging changing structures within education and social services departments and suggests:

the term can be applied irrespective of organisational structure...to cover instances of collaborative practice between different professional disciplines at both strategic and operational levels (2004, p.180).

Models of multi-agency working and its complexities

Atkinson et al’s (2007) review of multi-agency working indicated that multi-agency practice can be found across wide ranging areas. Examples cited include: early intervention or family support; working with disabled children; within crime prevention; child welfare and protection; drugs education and substance abuse;
and mental health. Certainly the review of literature within this research paper indicated similar multi-agency activity involving Looked After Children, disability, mental health, school exclusion and special educational needs (see Todd 2010; Daniels et al., 2007; Soan, 2006; Harker, 2004; Townsley, 2004 and Stead et al., 2004).

There is complexity too in terms of models of multi-agency working. Models include centre-based/co-location; coordinated response; multi-agency teams; meetings/consultation; school-based delivery; referral models; decision-making groups; operational delivery and joint-service delivery (Atkinson et al., 2007).

There are also different types of joint working such as multi disciplinary working which occurs amongst individual professionals working within a single agency with the focus essentially on the priorities of that agency; trans-disciplinary working which is a more holistic approach where different agencies work together and share aims, tasks and responsibilities and inter-disciplinary working where professionals across different agencies separately assess needs and meet to discuss finding and set goals (Watson et al., 2002).

Another example of the various descriptions of multi-agency working include autonomous – where there are separate services but individual professionals from different disciplines work collaboratively to achieve specific goals; coordinated - where professionals from different agencies assess separately the needs of children and families, meet together to discuss their findings and set goals; and integrated - where services are synthesised and coordinated (Townsley et al., 2004, p 27).

Multi-agency working is further compounded with various associations inherent within the language used. Soan (2006) suggests that multi-agency work should be inclusive and involve the family as partners but in reality families are ‘done to’ not ‘worked with ’and thus in effect are being ‘patronised by statutory authorities.
Soan (2006) argues that, ‘terms such as multi-agency or inter professional relate primarily to deficit models of intervention’ (p.212) and if the different agencies have different views as to what multi-agency work is then effective practice may not be achieved. Indeed, this aspect appears to feature with regard to social care practice and illustrates one of the difficulties associated with multi-agency working:

One example that highlighted key differences in social services and partner agencies approaches was the issue of service users’ consent. The social work team’s approach involved gaining families’ written consent before undertaking any work with them. Partner organizations working in voluntary sector agencies and universal services such as schools saw less need for this. It was seen as too formal an approach for use within agency settings that were characterized by informal contact with its users, such as drop-in centres. In a similar vein, some partners identified the social workers’ relationship with families as belonging to a tradition of statutory intervention (involving child protection) that was at odds with the approach of many partner agencies. In order to deliver a ‘seamless’ service with co-workers from other professions, partner agencies felt that some of the social workers needed more appreciation of ‘, having to negotiate rather than impose’ when working with families (Moran et al., 2007, pp. 143–151).

The term multi-agency working is used through this dissertation with reference to partnership working purely for ease and consistency. Thus, the term multi-agency is used henceforth and refers to joint and coordinated working and collaborative planning amongst professionals representing health, education and social care in the delivery of appropriate services to children, young people and families.

**Multi-agency working rationale**

The policy of multi-agency working primarily acknowledges the interrelatedness of child and family needs with respect to the fields of health, social services, the law, child welfare, housing and education (Salmon, 2004). The rationale
underpinning multi-agency working, in essence, relates to more efficient service delivery and greater efficacy resulting from joint problem solving, and that partnership working leads to improved outcomes for families. Further, that by working together, families receive a better service and that needs are met without duplication (Atkinson et al, 2007; Percy-Smith, 2006; Fox and Butler, 2004).

Irvine et al., (2002) suggest that there are also important ethical considerations for professionals to work together as:

one’s profession or agency alone cannot provide for all of the client’s health and welfare needs. This places professionals under a moral obligation to cooperate with others who may share a professional responsibility to alleviate hardship and suffering in individuals, families, groups and communities (2002, p.208).

**Benefits of multi-agency working**

The reduction of costs, reduced overheads and better value for money that is likely to result from multi-agency working are of natural benefit to any government with public service responsibility and, possibly, as important a consideration as better client outcomes. As Tomlinson et al., state, multi-agency working enables:

more effective services as a result of clearer identification of service gaps, improved integration and the overcoming of fragmentation, involvement of the community and service-users and the harnessing of resources of individual partners (e.g. financial resources, skills, information, political access and people) (2007, p.29).

The benefits of multi-agency working, however, may also be in the potential of exchanging ideas and expertise, as opposed to working in isolation, again for the
benefit of the client. One study indicated that professional identity was enhanced through multi-agency working (Gaskell and Leadbetter, 2009). Certainly, the positive impact of multi-agency working, as documented by Tomlinson et al., 2007, is evident; firstly, with regard to the benefits on professional development, wellbeing and working practices (the expansion of roles, the rewarding, stimulating and enjoyable nature of multi-agency working, and improved interagency communication respectively); and secondly, on service users and service delivery with the resulting easier access to services and improved support and educational attainment. Indeed, research by Robinson et al., 2008, specifically point to the potential benefits of integrated service delivery upon users:

improved access to services and a speedier response, better information and communication from professionals, and improved attainment (p. viii).

Hartnell (2010), in a recent, though small scale study relating to teenage service users, refers to successful multi-agency collaboration, leading to improved pupil behaviour and confirming the positive impact of effective multi-agency work can have:

young people were able to provide examples of the tangible benefits to them from multi-agency working... and they could point to the specific ways in which multi-agency working had benefited them and their families (cited in Harris and Allen, 2011, p. 408).
Implementation of multi-agency working

Although there is significant consensus within the research undertaken as to the value of multi-agency working, there is also much evidence to show that policy does not easily translate into effective action and practice as the numerous citations, some exemplified below, within the research undertaken indicate. As Anning (2005) suggests, perhaps more research is needed to support understanding and ability to deliver government imperatives of cohesive multi-agency service delivery.

Indeed, from a policy implementation perspective, Dyson et al., (2009) are critical of the previous government’s implementation, documenting the inherent difficulties with multi-agency working, such as ambiguity of purpose and practice, cultural difficulties, practicalities of implementation and contradictions of policy. They refer to multi-agency working as being ‘badly under conceptualised and under specified.’ Their argument is that while the Labour Government advocated for collaboration, aspects of policy were not duly aligned. One was left with discordance between policy at the centre with delivery at local level:

... high level of policy activity at the centre and an overwhelming desire to manage working practices on the ground, without the corresponding capacity to think issues through in depth or deliver workable solutions to practitioners. As in the Neighbourhood Renewal Strategy, the absence of a fully-worked out ‘vision and strategy’ at the centre leads all too often to an injunction to practitioners and decision makers at the local level to ‘join up’ the fragmentary mandates of national policy (pp.7-8).

Furthermore, Calder’s (2004) analysis of outcomes with regard the Integrated Children’s System and Looked After Children indicates that the underpinning Assessment Framework, brought in to standardise assessment and rebalance child protection to the child in need, had not attained its objectives. Calder suggests this
was due to significant obstacles, one of which being the ability of agencies to work
together despite government directives to do so, and states:

There is ample evidence in the child protection arena that individuals and
agencies have found it most difficult to cooperate not least in successive
high-profile child abuse inquiries. This goes beyond individual personality
conflict and professional incompetence. They are rooted in a variety of
differences in values, practices, perspectives, and professional ethos, arising
out of a range of social, cultural and historical processes (p.229).

Effective multi-agency practice

From the review of literature, there were clear examples of effective multi-
agency practice which highlighted certain common factors such as;
commitment; understanding of professional roles and responsibilities; common
aims and objectives, effective communication and information sharing; effective
leadership and drive; relevant personnel; sharing and access to funding and
resources, senior and front-line staff commitment; and appropriate timetables
for policy implementation and change (Atkinson et al., 2005; Sloper, 2004;
Atkinson, 2000).

In particular, effective multi-agency practice was highlighted with regard to
case studies of successful partnership working with specific groups of children,
e.g. concerning pupils with disabilities, special educational needs or who are
Looked After, all of which emphasise the key factors of successful collaboration
of time, professional expertise, funding and common purpose (Harris and
Allen, 2011; Hartnell, 2010; Soan, 2006; Harker et al., 2004, Lloyd and Kendrick,
2004; Stead et al., 2004; Townsley 2004; and Watson et al., 2002).

However, what was also evident in the literature was the emphasis on
professional views, as opposed to service users:
Whilst the impacts on professionals involved in multi-agency working appeared to be often cited and well evidenced, empirical evidence for impacts on service users was sparse. Given the current climate, which places much emphasis on multi-agency working and the attention given to the client’s voice, this would seem an important area for further research (Atkinson et al., 2007, p.42).

Furthermore, many of the case studies presented focussed on those often associated with specific government initiatives relating to Sure Start, Health Action Zones or Education Action Zones, or on particular pilot projects or specific contexts (Soan, 2006; Glenny, 2005; Mailin & Morrow, 2007; Milbourne et al., 2003). Thus, the multi-agency work tended to be reliant upon project funding rather than mainstreaming provision or consistent or general local authority or health practices; “many collaborations lack durability and many do not work out in policy or in practice” (Stead et al., 2004, p.42).

Indeed, much of the literature research is littered with exemplar small scale multi-agency working practices, as well as commentary, regarding the factors that impede or facilitate successful working. As Warmington states:

many of the recent key developments in forms of social provision which aim to enhance the capabilities of children, young people and their families by addressing their complex social needs have been predicated upon forms of inter agency collaboration... These have included initiatives such as the Social Exclusion Unit, Sure Start, Education Action Zones, Health Action Zones, Connexions, the Children’s Fund and Children’s Trusts. However, professional boundaries between agencies, expressed in disparate goals, perspectives and priorities, have often impeded inter agency working. At policy level ‘joined up’ working is promoted as a ‘self-evident good’ but strategy and operation both remain problematic (2004, p.3).
Difficulties associated with multi-agency working

Tomlinson et al., (2007) provides significant evidence of the difficulties associated with multi-agency working such as professional confusion over role and identity, uncertainty of professional status, persistence of duplication and increased workload. Research evidence indicates professional collaboration and coordination is often poor with “interprofessional relationships ...characterised by conflict” (Irvine et al., 2002, p.199).

According to Harris and Allen 2011:

Multi-agency professionals frequently talked about tensions involved in multi-agency work and identified a lack of coherence, inadequate collaborative structures, budgetary constraints and the differential remuneration of various professional groups as problematic (p.413).

Leadbetter et al’s., (2007) research into five different inter agency children’s services teams across the country between 2004 -2007 revealed difficulties such as co-location issues and conflict regarding professional identity. Anning (2005) argues that the complexities of multi-agency working appear to be overlooked by directives and not acknowledged by those making policy decisions; an assumption that public money transcends a perceived problem:

Professionals in the UK have been told that Early Childhood Communities are fortunate to have been given so much money and that they are expected to get on and make ‘joined- up thinking work’ (p.43).

Anning’s (2005) evaluation of two government model Centres of Excellence refers to the unacknowledged areas of potential conflict surrounding professional systems of beliefs and values – the expectation of practitioners operating at:
highly sophisticated level[s] in juggling the competing demands of their traditional professional values / beliefs with each other and at the same time with those of their host communities (2005, p.43).

Atkinson et al., also references the difficulties that stem from deep seated service held ‘principles’ and own ‘philosophies’ (2002, p.132). There is no doubt that issues of inter professional understanding of roles, responsibilities, approaches, cultures and theoretical conceptualisations abound, all impacting on effective collaboration (Robinson and Cottrell, 2005; Hudson, 2002). Current researchers (Harris and Allen, 2011, Horwath and Morrison 2007; Frost and Robinson, 2007) continue to emphasize the complexities and ambiguities of multi-agency practice:

Most professionals regard boundary issues as the major challenge in moving towards more integrated and multi-agency provision after many years of separate working. Consequently, trust across agencies was varied and there was evidence of competing power relationships between various organisations. Multi-agency professionals frequently talked about tensions involved in multi-agency work and identified a lack of coherence, inadequate collaborative structures, budgetary constraints and the differential remuneration of various professional groups as problematic (Harris and Allen 2011, p.413).

Despite the difficulties related to multi-agency working there is nonetheless the acknowledgement that new ways of working together are necessary if better outcomes for children are to be achieved (Leadbetter et al., 2007). However, most of the literature relating to multi-agency working appears to focus more on the processes involved as opposed to the actual impact or outcomes on service users:

While there is at present sufficient evidence testifying to the impact of early-intervention on outcomes for children and families..., there is as yet only limited evidence (and conflicting findings) concerning the impact that multi-agency working has on outcomes for children (Moran et al., 2007, pp.143–151).
Atkinson et al.’s., (2007) study of multi-agency working summarises succinctly the barriers and facilitators to effective multi-agency work. The corresponding challenges and facilitating factors, “inextricably linked” (p.43), are broadly organized into four main categories: working relationships; multi-agency processes; resources for multi-agency work; and management and governance. The table below indicates the corresponding sub factors relating to these categories as indicated by Atkinson et al.

**Table 3 Factors that facilitate and provide challenges to multi-agency working adapted from Atkinson et al., 2007.**

<table>
<thead>
<tr>
<th>Working relationships</th>
<th>Role demarcation</th>
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<tr>
<td></td>
<td>Commitment</td>
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<td></td>
<td>Trust and mutual respect</td>
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<td></td>
<td>Understanding other agencies</td>
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<tr>
<td><strong>Multi-agency processes</strong></td>
<td>Communication</td>
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<td></td>
<td>Clarity of purpose</td>
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<td></td>
<td>Planning and consultation</td>
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<td></td>
<td>Organisational aspects</td>
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<td>Information exchange</td>
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<td><strong>Resources for multi-agency work</strong></td>
<td>Funding</td>
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<td></td>
<td>Staffing</td>
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<td></td>
<td>Time</td>
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<tr>
<td><strong>Management and governance</strong></td>
<td>Leadership</td>
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<td>Governance and accountability</td>
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<td>Performance management</td>
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The section below considers in detail the main barriers to facilitators of multi-agency working.

**Barriers and facilitators regarding multi-agency working**

Multi-agency working has seemingly many challenges and hurdles to overcome to ensure effective delivery of services if there is to be any real success relating to subsequent improved educational outcomes.

Table 4 below summarises the barriers and facilitators to effective multi-agency working that repeatedly emerge from the review of literature. The specific cases relating to multi-agency working were analysed and the barriers and facilitators noted accordingly, serving to demonstrate the complexity and depth of difficulties associated with multi-agency working. The table sets a framework in which to understand the key issues arising.

**Table 4 Barriers and facilitators to multi-agency working from the review of literature**

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Facilitators</th>
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<tbody>
<tr>
<td>Different conceptualisation of role, purpose and practice Tomlinson, 2007</td>
<td>Infrastructure in place Frost, 2006</td>
</tr>
<tr>
<td>Historical barriers Leadbetter <em>et al.</em>, 2007</td>
<td></td>
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<tr>
<td>Bureaucratic and organisational barriers Cameron and Lart, 2003</td>
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<tr>
<td>Lack of common language Harris and Allen, 2011, Watson et al., 2006, Healey, 2004</td>
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<tr>
<td>Communication Sloper, 2004</td>
<td></td>
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<tr>
<td>Single agency discourse Abbott et al., 2005</td>
<td></td>
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<tr>
<td>Impact of Government legislation Skinner &amp; Bell, 2007</td>
<td></td>
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<tr>
<td>Perceived hierarchies Milbourne, 2003</td>
<td></td>
</tr>
<tr>
<td>Fear of litigation Glennie, 2007</td>
<td></td>
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<tr>
<td>Poor management Milbourne et al., 2007</td>
<td></td>
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<tr>
<td>Policy contradiction Dyson et al., 2009</td>
<td></td>
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<tr>
<td>Lack of understanding Leadbetter et al., 2007</td>
<td></td>
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<td>Lack of training Alnock, 2006</td>
<td></td>
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<tr>
<td>Own thresholds relating to child protection identification Irvine et al., 2002</td>
<td></td>
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<tr>
<td>Workload Tomlinson, 2007</td>
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<tr>
<td>Lack of trust Sloper, 2004</td>
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<td>Different values and boundaries Warmington, 2004</td>
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<tr>
<td>Differing beliefs Anning, 2001</td>
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<tr>
<td>Challenge to professional identity Leadbetter et al., 2007</td>
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<tr>
<td>Ambiguity of partnerships Leaman, 2004</td>
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<tr>
<td>Conflicting priorities Leadbetter et al., 2007; Leaman, 2004, Healey, 2004</td>
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<tr>
<td>Cultural differences Dyson et al., 2009</td>
<td></td>
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<tr>
<td>Confidentiality issues Frost and Robinson, 2007</td>
<td></td>
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<tr>
<td>Stereotyping through discourse Bell and Allain, 2011</td>
<td></td>
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<tr>
<td>Role and identity Tomlinson, 2007</td>
<td></td>
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<tr>
<td>Financial resources Watson, 2006, Allnock et al., 2006</td>
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<tr>
<td>Respect Watson, 2006</td>
<td></td>
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<tr>
<td>Defined roles and responsibilities, clear lines of responsibility and accountability Sloper, 2004</td>
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<tr>
<td>Joint planning Harker et al., 2003</td>
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<tr>
<td>Investment in joint training and inter professional learning opportunities Healey, 2004</td>
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<tr>
<td>Performance management Fox and Butler, 2004</td>
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</table>
The factors that inhibit or facilitate effective multi-agency working may best be divided predominantly into organisational, or structural, and cultural difficulties (Atkinson et al., 2005; Milbourne et al., 2003; Irvine et al., 2002).

The review of the joint working literature suggested that there is some association between the type of model of joint working and the factors promoting and obstacles hindering progress. .... both organisational and cultural/professional problems (Cameron and Lart, 2003, p.15).

These factors are now looked at in more detail below.

**Organisational / Structural factors**

The breadth of organisation challenges to effective multi-agency working appear to be vast and complex, ranging from funding and sustainability issues to those relating to time allocation and staffing (Stead, Lloyd & Kendrick, 2004). Organisational challenges to multi-agency working also relate to the different policies, systems and structure inherent within the key children’s services which can be problematic (Robinson et al., 2008). One organisational barrier cited in the review of literature was the technical difficulties that professionals experienced, for example, incompatible IT systems and lack of an integrated system for information sharing which often led to poor communication (Anning et al., 2007; Sloper, 2004).

Other barriers cited regularly in the literature included the differing protocols and procedure, personnel and referral systems; differences of hours and structures of day worked; differing workload, different pay scales and hierarchies; all significant organisational issues impacting upon effective multi-agency working. Difficulties of collaborative working due to management and hierarchical difficulties were apparent in one study through, for example:
problems stemming from management change resulting in different assumptions and project direction, tensions over qualifications, professional status and expertise, access to equipment and physical location. The latter meant that there was an inherent hierarchy – the team was located within a health office and thus ‘health takes the lead in terms of being the owner of the project (Milbourne et al., p.26).

Consideration, within the literature, is also given to the contradictory policies that act as inhibitors to multi-agency work. The difficulties of competing priorities such as government targets and prevention versus intervention are well documented (Leadbetter et al., 2007) and the often incompatible duality of the drive to raise attainment while addressing the needs of the educationally challenged. An example of such conflict of interest relates to the dichotomy of performing well in government education led league tables and serving the needs of those pupils with significant emotional and behavioural needs which can all militate against effective inclusive practice (Leaman, 2004; Allnock, 2006).

**Cultural factors**

Studies, for example those by Anning, 2005; Sloper, 2004 and Freeman et al., 2000, indicated that ethical and professional barriers can impede relationships and thus multi-agency working. Further, the particular professional culture or ethos of a child service can give rise to tensions when attempting to work collaboratively across service providers. Cultural difficulties within multi-agency working, such as understanding and valuing of each other’s role, and lack of professional trust, all add to the difficulties of collaborative working.

Professional stereotyping and misconceptions of professionals within a team were common threads within the literature. There was particular distrust, misconception and lack of respect with regard to social care professionals:
... that social workers are about taking children off their parents, so some doctors are reluctant to make referrals anyway, because they think they will move in a very heavy handed way, and that the medical staff’s relationship with the families will be totally destroyed (Frost and Robinson, 2007, p.189).

Some social workers were sceptical about Sure Start Local Programme staff trusting them to do their best for families: I feel that some people who provide support to families hold back in reporting issues to Social Services, and this makes things even more difficult for us...It is essential that different professional groups respect and acknowledge the value of ‘others’ in order to establish trust around information sharing and appropriate referrals (Allnoch et al., 2006, pp. 33-37).

Bell and Allain (2011) suggest, albeit based on a small research project, that professionals hold certain stereotypical perceptions about other professionals. They found that student social workers, while acknowledging the importance of inter professional collaboration they had inherent stereotypical views about them:

Students appeared to be expressing stereotypes held about professionals, such as doctors, derived from popular discourse; for example, being deferential and revering the expertise of the medical profession, whilst also criticising the dominance of the medical model within their own practice experiences, or doctors’ perceived lack of ‘team’ spirit as an aspect of collaborative working (p.276).

There was evidence too, that, at times, there was a tendency for health professionals for example, to denigrate other professionals:

Health professionals in particular were unhappy about some health-related activities being delegated to colleagues they saw as lacking in the necessary knowledge and experience base. .... support workers’ sometimes felt that the professional staff ‘looked down’ on them and failed to recognise that their roots in the community enhanced their ability to fulfil their work roles (Allnoch et al., 2006, p.35).
Further, health professionals, at times, appeared to treat other staff with little respect and considered certain staff were really peripheral to the multi-agency team and not essential; “health professionals ... more traditionally set a high cultural value on professional status differentials” (Frost and Robinson, 2007, p.195).

One of the reasons behind multi-agency professional cultural conflict may stem from professionals being trained in different ways as each profession has own its own professional direction:

specialisation at the expense of common theories and methods and parochialism—a lack of international exchange or cross-cultural content in many courses (Axford et al., 2006, p.163).

Several researchers refer to the clash of professional cultures (Malin & Morrow 2007; Howes & Fox, 2004; Stead, 2004; Sloper 2004, and Milbourne et al., 2003). Own traditions, priorities, and beliefs and values (Anning, 2005) are all significant cultural barriers and, at times, ‘antithetical philosophical and political principles,’ (Edgely and Avis, 2006, p. 434) clearly have a negative impact on multi-agency working. The differences may be explained as being:

located in the terms of the networks and cultural capital brought from previous experience and constructed from class, gendered and racialised identities... and can serve to exacerbate existing tensions (Milbourne et al., 2003, p.27).

The fear of loss of professional identity, lack of role understanding and protectionism of one’s status were common indicators within the literature that impacted negatively on effective multi-agency working and service delivery:
You can be really confident and assertive in your own professional area but as soon as you’re moving in different circles, working with other agencies or professions, you feel intimidated. You feel intimidated because there is a lack of understanding about what each one does. (Leadbetter et al., 2007, p.95).

There are people who protect and hold their given level of expertise and think it is better than somebody else’s. Sometimes, if the CAMHS worker makes a CAMHS referral to a mental health service, we’ll get a service. If a social worker does it you wait for the service (ibid, p.96).

Allnock et al., (2006), with reference to Sure Start inter agency working, argues that often the professional/non-professional tension emerged which exacerbated underlying inter-professional tensions between staff members:

Staff with a particular expertise, such as working with children with special needs, sometimes argued that their colleagues (including both health visitors and Sure Start home visitors) lacked the same level of skill. Conversely, those with a professional background in working with the local community (or Sure Start staff drawn from the community) often contended that other professional staff needed more training in how to work with families in the community (p.35).

Cultural issues were particularly apparent with regard to professional views concerning the qualifications held by children’s service staff within the multi-agency team:

...there are ideas around qualifications, and who’s got the best qualifications. There’s quite a lot of snobbery around, you know, what your qualification is, which discipline you belong to (Milbourne et al., 2003, p.26).

I think there is a lot of work to do about bringing organisations out of the box that they exist in...about being protective about their qualifications and skills base they think is theirs (Leadbetter et al., 2007, p.95).
Another cultural barrier to effective collaboration stemming from a variety of studies, (Marsh, 2006; Francis, et al., 2006, Anning, 2005; Irvine et al., 2002) are the different priorities that shape the work of different professional groups. This may be seen, for example, with the service differences regarding definition of crisis situations. Professionals across the key children’s services tended to implement their own reference frames and thus make judgements and priorities of response based on own thresholds. Reference frames are used whether to prioritise a particular case or not, refer on, or act upon later; issues can also arise relating to prevention or treatment. This can cause friction between professional organisations:

Differences between the professionals may become especially problematic in cases which the referral agent defines as ‘crisis situations,’ i.e. those requiring a rapid concrete response or decision. When other professionals apply their own frames of reference to make sense of a situation…they may differ intensely over the priority the case is assigned….the use of such priority systems may be source of conflict when workers do not share the same values, when the original problem is deemed to have been ignored, devalued or dismissed, or when feedback after referral is poor (Irvine et al., 2002, p.204).

Issues of confidentiality, the dilemma of undertaking preventative versus crisis intervention and different services having different thresholds for action clearly causes problems for collaborative working:

... the social worker felt that there was a cultural difference between social services and health agency norms: There are issues around confidentiality, health records.....you can’t access that information. I’m used to working in an arena where we share things all the time and so to have somebody come in with a very strict confidentiality policy makes it very difficult (Frost and Robinson, 2000, p.188).
Expert language

The use of ‘expert’ language, at times referred to as technical language or jargon, often added to a perceived cultural status of certain service providers which thereafter lead to professional exclusion. Not understanding such expert language can put professionals within multi-agency meetings at a disadvantage both psychologically and professionally, and more importantly, can impact negatively on outcomes. Indeed, use of jargon can entrench differences of power between staff and be used to exclude staff, further inappropriate jargon is not always challenged (Frost, 2005; McInnes, 2007). There is thus a clear need for cross discipline training with regard to concepts and language as a way to break down barriers relating to effective service delivery (Watson et al., 2002). Healey (2004) found that the dialogue between health and education was difficult due to the ‘different languages’ (p.6) that they spoke.

The lack of a common language and a framework in which all children’s service professionals can use to talk and understand children would appear to be an area that needs to be addressed. Effective partnership requires compatibility of terms and phrase used across service providers (Dahl and Aubrey, 2004). It appears too, that getting professionals to agree on certain definitions and hold common understanding can be a ‘complex challenge’ due to a variety of reasons such as: “role, their agency, their corresponding aims and responsibilities and other personal and professional factors (Hicks and Stein, 2010, p.7).

While organisational barriers of multi-agency working can be removed through legislation and joint governance, aspects of cultural barriers are not as easily removed. Indeed, many of the New Labour reforms, in principle, swept away organisational barriers and created structures that were far more flexible and no longer bound by individual services. Multi-agency teams rarely existed prior to
the reforms. It thus appears that the cultural difficulties are the hardest to surmount.

Agency marginalisation due to, for example, lack of respect given from other agencies, lack of a common language, historical prejudice and inter professional rivalry are all cultural barriers that adversely effective multi-agency working. One persistent cultural barrier evident within the literature appears to relate to the status of health and its perceived doggedness of retaining superiority over other children’s service professionals. It is perhaps worth considering the role of health in more detail as the literature does appear to give an emphasis on this area as a significant barrier to multi-agency working.

Health barriers

The dominance of health as the ‘leading contributor’ to difficulties relating to inter professional relationships and effective multi-agency partnerships is significant thread across the literature. Reasons given have included the distinctively hierarchical structures of health services, ‘latent professional snobbery’ and the conceptualised dominance of the medical model (Todd, 2007; and Allnock et al., 2006; Irvine, 2002):

Relationships with health agencies were often seen as problematic. Hierarchies in health trusts could militate against comfortable or collaborative relationships with non-health professionals. In addition, the tendency of health professionals to explain issues on the basis of the ‘medical model’ was sometimes seen to prevent them recognising the potential contribution of other family support services (Allnock et al., 2006, p.34).
It appears that the reluctance for change is a barrier for progression and specifically the reluctance of health to be positive partners in multi-agency working. Further, that such practice is, in medical circles, viewed with suspicion as it was brought in because:

multidisciplinary practice was viewed as a panacea for inefficiency in health service delivery, for communication failure within and between disciplines and for professional separatism (Harker et al., 2004, citing Irvine et al., 2002, p.201).

There is some truth in this as, after all, part of the rationale behind the Common Assessment Framework was to ensure a multi professional way of assessment to prevent repeat referrals and lack of coherent or joined up interventions. However, medical dominance as a barrier is perhaps better viewed due to its longstanding history and grounding:

... medicine is an older profession than social work and therefore has a more developed conceptual and theoretical base. Medical concerns affect everyone, whereas social services have tended to serve predominantly poor and disenfranchised children and families; thus, while there is consumer demand for well-trained doctors and money from pharmaceutical companies to fund research into diseases and treatment, fewer such demands have existed in social services (Axford et al., 2006, p.163).

Furthermore;

In the case of medicine, power is embodied in and comes with the day-to-day rational-scientific practices associated with the work of doctors in the hospital or clinic, which Foucault (1973) termed the ‘clinical gaze’. ...institutions such as medicine ... exercise power not through overt coercion but through the moral authority over patients associated with being able to explain individual problems (such as an illness) and then provide solutions (i.e. treatment) for them (Crinson, 2007: no page reference).
Another explanation for health’s dominance may be found in the entrenched culture of the health profession where traditional decision making and authority rested “in the hands of a professional elite, with medicine at the top of the pyramid” (Irvine et al., p.203). The latter refers to the autonomy and dominance built by the medical profession with its overarching and perceived superiority relating to education, class, gender and income, over the lesser considered field of social work, dominated by women and representative across the social classes but crucially with “less educational attainment” (p.203).

This ethos is now challenged by non medical groups but can be a source of relationship friction as there appears to persist an ‘ingrained professional arrogance’ within the medical world:

The persistence of medical dominance in teams and top-down approaches to interdisciplinary relationships continues to be a source of considerable tension for non medical groups (Irvine et al., 2002, p.204).

Another explanation may be found with regard to the importance of medical knowledge throughout history and thus status that the profession has held within society:

the history and development of professions has largely been based on securing status through exclusive knowledge and demarcation (Bines, 1992 cited in Leadbetter et al., 2007, p.126).

The dominance and autonomous power of the medical profession over non medical organisations (Irvine et al., 2002) and the predominance of the medical model are significant barriers to effective multi-agency working. Part of the explanation for such dominance may lie in the particular entry requirements to the medical profession which are far higher than other children services, and, as an
older profession, one with a “far more developed conceptual and theoretical base” (Axford et al., 2006, p.163). One study showed that professionals with medical training in multi-agency teams tended to dominate discourse especially over the approaches and ideologies of social care professionals who often thus felt marginalized (Abbott et al., 2005).

Thus, cultural barriers appear deep seated and consideration of how one surmounts such difficulties is discussed later in this chapter.

Additional barriers

The review of literature undertaken also reveals a dimension to the difficulties that fall outside cultural and organisation demarcation such as the fear of litigation and the psycho dynamic aspect of interaction including anxiety, fear, recrimination and blame (Glennie, 2007). Overarching issues relating contextual barriers, political climate, changes in political steer and agency reorganisations can also be regarded as examples of particular challenges. Further:

the local context can generate additional challenges to integrating services. Local issues can be at odds with meeting national priorities and there can be conflicting internal priorities between agencies.....There can also be local issues of lack of coterminosity between agency boundaries, for example, between PCTs and local authority boundaries, which can cause significant obstacles to working across agencies (Robinson et al., 2008, p.74).

Allnock et al., (2006) cite the example in their evaluation of Sure Start: “Where health was the lead, tensions could surface in respect of separating out PCT objectives from wider SSLP objectives” (p.32).
Multi-agency working is clearly affected by a variety of factors be it the different perspectives of individual within a team, the inherent cultural and organizational / structural problems. Suspicion amongst professionals, hostility and disparities of practice and philosophies all impact on effective multi-agency working (Irvine et al., 2002). With such negativity seemingly abundant amongst professionals towards collaborative working, it is a wonder any good practice exists.

Summary of difficulties

The review of literature undertaken indicates a high degree of commonality with regard to the challenges of multi-agency working. It is hardly surprising then, when researchers such as Easen et al.,(2000) and Todd (2007) refer to the poor track record and problematic nature of effective multi-agency collaboration. The difficulties of multi-agency working can clearly be divided into cultural and organisation categories. Organisational aspects such as separate targets, different hierarchies, boundaries and accountability structures impact clearly on service ability to work together. Cultural difficulties such as professional conceptualisation, autonomy of health, closed professional terminology, lack of a common language and framework in which to discuss and understand children across the key children’s services also have a negative impact on services working together. A more practical way forward should thus be considered.

What then is perhaps needed?

Research

Further research into effective collaboration may be of relevance; the literature review undertaken tends to expound conceptual models of collaboration, but really gives little insight as to what actually makes it work, especially with regard
to large scale models (see Mailin & Morrow, 2007; Soan, 2006; Warmington et al., 2004).

Moreover, although one can find exemplar small scale multi-agency working practices the preponderance within the literature is with local, as opposed to national, examples of effective practice (Tomlinson et al., 2003).

**Joint Training**

There is a need to ensure professionals receive appropriate training with regard to multi-agency working. Researchers regularly stress the requirement for multi-agency education and training amongst service providers in order to achieve more effective inter professional work (Glennie, 2007; Frost & Robinson, 2007; Marsh, 2006; Edgely, 2006; Atkinson et al., 2005; Irvine, 2002; and Freeman et al., 2000):

Professions create their own distinctive cultures through their training procedures and the pronouncements of its professional bodies and through on-the-job socialisation. Neophyte professionals acquire, through their education and training, a manner of conceptualising facts, definitions of clients, causal explanations and views on treatment. Such ‘facts’ include definitions of the situation, the person (patient, client, community, organisation, citizen) and the person’s problems. Later, these ‘facts’ shape and inform professional interventions and the approach to these interventions (Irvine, 2002, p.207).

Indeed, the guidance in Working Together (HM Government, 2010) stated that if professionals were to be able to work effectively together then inter agency training had to be a priority. There needed to be:

- a shared understanding, improved communication, including a common understanding of key terms and definitions, in order to achieve better outcomes for children and young people (p.91).
Focus on cultural aspects

It appears that previous government policy was focussing on the structural and organisational aspects relating to effective multi-agency working but little was really being done to tackle the inherent cultural barriers. Certainly, Bachmann et al’s (2009) national appraisal of ‘Pathfinder’ Children’s Trusts found that the much of the restructuring within local authorities has been “more about changes in management structures” (2009, p.364).

It may well take more than legislation alone to improve multi-agency working due to the “immutable boundaries” (Harris and Allen, 2011 p.415) that currently exist for children’s outcomes to improve:

- multi-agency teams require deep-rooted cultural change to ensure that different professional groups work together effectively across various organisational boundaries and fault lines (ibid, pp.405-6).

Multi-agency collaboration may not be easy to achieve given that there appears to be an inherent complexity in tasking professionals to work together due to the ‘sociology of professionalism’ (Hudson 2002, cited in Frost 2005, p.12). Frost suggests that “professions are defined by what makes them distinctive rather than what brings them together” (p.12) and refers to Loxley’s (1997) observation that:

- Conflict is interwoven with inter-professionalism because there are deep rooted social differences in the division of labour which have developed over the last 200 years in the health and welfare service (Hudson, 2002 cited in Frost, 2005, p.33).

The ‘intangible’ and ‘deep seated barriers’ in relation to joined up working due to ‘underlying division and rivalry,’ are well certainly well evidenced (Frost, 2005, p.33). The power that the medical world has over education and social care appears
to be a significant barrier to multi-agency working. Much is perhaps made of the influence of health within this research primarily because of its apparent dominant force and overarching influence relating to multi-agency working. Certainly, as seen earlier, health appears to be a formidable barrier to effective multi-agency working and promotes a hierarchical framework in which others are perhaps required to conform.

There are perhaps two significant cultural difficulties that seemingly underpin the difficulties of multi-agency working, that of a lack of common conceptual framework and language. These are looked at in the section below.

**A common conceptual framework and language**

Children’s service professionals see and understand children in different ways. To have different professionals seeing children in the same way and using a language that all professionals understand is no easy task. The issue of professional conceptualisation appears entrenched, due to the ‘process of enculturation’, (Easen et al., 2000, p.357) and to the ‘complexity of interaction and social practise’ (Todd, 2007, p.84). Different conceptualisations that professionals across the key children’s services hold can lead to dysfunction in a system aimed at support, and lack of coherence. Indeed:

> Practitioners could benefit from a common conceptual framework that is used across agencies to help understand and respond consistently to children’s difficulties (Axford, 2006, p.163).

**Conceptual differences**

The medical profession is based on science and biomedical understanding of illness and thus:
... suffering is reflected in the material practices of the medical profession, which for over a period of two centuries has been able to establish its dominance within the evolving organisational system of health care. It is through such practices that the power of the biomedical discourse of health and illness has become socially embedded. In this sense, medical knowledge and power has long been regarded as a defining feature of modern health care systems (Crinson, 2007: Section 2).

Todd (2007) refers to the ‘systemic embodiment of the medical model’ (p.89) that underpins the integrated service delivery model. That service delivery is built upon the ‘theory’ that something is wrong and ‘needs fixing’: a deficit model with the client having an inherent problem with little regard to the contextual influences that abound: “a complex interaction of social practices and institution, political and cultural influences” (p.89).

This deficit model is antithetical to social frameworks of practice that consider environmental and societal factors as influences on child development e.g. social care, and thus framework commonality is required otherwise the existing cultural differences will be perpetuated.

With medical, social and psychosocial models being utilised across the key children’s services, one has to ask can professionals work together effectively if they think conceptualise children if different ways? Indeed, as Dyson et al., (2009) argue, government policy that focused upon structural reform in order to integrate services does not guarantee that different professionals from different agencies will come to “see the world in the same way” (p.144).

There are many examples of how different conceptualisations affect how professionals work and how confusion about the meaning and significance of different terminology hinders effective communication and can lead to
misunderstandings. One such example may be found with regard to the conceptual frameworks used in relation to mental health. The term mental health can mean different things to different people depending on professional background, lay interpretation and context. The term mental health can be socially constructed or can be defined as an absence of a major mental health condition. It can be understood as a sociological relativistic concept, or from a holistic or a pathology perspective. The fact that mental health improvement involves a wide range of people from many diverse backgrounds, ‘with different experiences and traditions, different expertise and different ways of thinking about mental health’ makes effective partnership problematic (Friedli, no date given).

There is a similar difficulty with the conceptualisation and understanding of the term psychosocial. The general lack of consensus regarding the definitions and usage of psychosocial concepts evidenced in the research literature can lead to different approaches to address particular needs. For example, with regard to the emotional needs of displaced persons and refugee/asylum seeking families, the ‘umbrella term’ of psychosocial is applied to a whole host of diverse programmes ranging from human rights, community engagement to therapeutic work (Egan et al., 2008).

Similarly, the concept of well being with regard to children is highly complex due to the various and diverse usage of the term. Ereaut and Whiting (2008) refer to the “significant ambiguity around the definition, usage and function of the word ‘wellbeing’” stating that the term now has “holographic qualities” due to the differences of uses and stance. The term is used, for example by the DCSF, philosophically, operationally, medically and emotionally. It is clearly ambiguous. The term well being is considered ubiquitous and its very “malleability makes clarity elusive and accountability for ‘wellbeing’ problematic” (Ereaut and Whiting, 2008, p.8)
The different practitioner backgrounds and conceptual understandings can lead to little or no real consensus and thus particular perspectives are defined by particular emphases (Strang and Ager, 2001). Subsequently, fundamental misunderstandings can arise with regard to appropriate support and interventions when working in a multi-agency setting. The problem arises with different professionals constructing different meanings that makes sense to their own profession or organisation, and perhaps more cynically for their own specific benefit to facilitate own processes and objectives.

Such different conceptualisations can have detrimental effects and can extend across to working with families, policy development, multi-agency working and with regard to accountability. As Todd (2007) suggests:

> the ‘norms, discourses and conceptualisations of professional practice have to be examined’ if collaboration is to be effective and meaningful (p.18).

Professional conceptualisation certainly appears to be one of the key factors that prevents effective multi-agency collaboration. There is nothing new in the fact that different professionals see thing differently. It is part and parcel of individual professional training, and the ‘how things are done’ ethos within any organisation. Todd (2007) suggests that the way professional perceive and work with clients is in the very ‘ether’ of institutions and that professional practice is inextricably linked to social constructionism: ‘the assumption of a model of expertise infuses all practice’ (p.121).

**Lack of a common language**

The current lack of a common language is also particularly pertinent and finding a shared common language to discuss children is an important element of successful
partnership work. As Friedli suggests there are a number of barriers ‘to realising the dream of a common language’ given the different stakeholders with different perspectives and experiences (No date given, p.4).

Professionals at times use the same words but they have entirely different meaning and thus understanding. This aspect of language misconception was verified by Salmon and Rapport’s 2005 study of discourse between service providers. The study indicated that there was often confusion over terminology used and that multi-agency professionals rarely sought clarification of language. The latter was put down to either because of reasons pertaining to being inhibited or that professionals were not actually aware that there may be a different understanding and thus ‘the different meanings eschewed continues to exist in the minds of the different professionals’ (p. 439). Indeed:

It has been suggested that many of the difficulties encountered in supporting children in need are to do with difficulties of communication. For example, when professionals use the same words as each other, but apportion them with different meanings, in the belief that agreement has been reached in conversation, when in fact those conversing are at odds with one another (Salmon and Rapport, 2005, p.430).

Across the core children service providers, terminology has different connotations and language used is often jargonistic, leading to misunderstanding and conflict in a multi-agency setting. Jargon can often be used to reinforce power differences serving to exclude rather than include other professionals and thus Frost’s call to professionals to ‘challenge its use’ (2005, p.50). Professionals perhaps need to find a common language to make knowledge accessible to their colleagues from other disciplines rather than persisting with technical language (Robinson & Cottrell, 2005). Indeed; “all professions have fabricated esoteric language that is inaccessible to those outside the discipline” (Irvine et al., 2002, p.206).
The different perspectives and understandings that professionals have are clearly reflected in language used, often hindering professional collaboration and ultimately, leads to poor service delivery:

Terms such as ‘culture’, ‘maladjustment’ and ‘deprivation’ have different meanings and entail different responses from health workers, social workers, community workers and teachers, depending upon whether ‘maladjustment’ is conceived as located in the client or the institution. Major assumptions about the nature of society and the role of the professional underlie the use of such terms and differentiate the professions. Thus, common terms that seem to draw together human service workers, insofar as they are related to differing conceptual frameworks and to differing roles and tasks, may serve to endanger rather than enhance the capacity for interpersonal co-operation (Irvine et al., 2006, p.206).

Todd argues that we need to deconstruct language if there is to be greater awareness of professional roles. Terms used by professionals such as ‘need’ or ‘difficulty’ are ‘all constructed terms’ (p.19) and can mean different things to different people and professions, and one has to considers if they are they are thus helpful concepts to have. Todd suggests that:

some discourses of professional practice – such as having expert knowledge and constructing problems and their solutions in terms of the medical model (for example) call professionals into certain ways of seeing people with whom they work and certain kinds of relationships with clients (2007, p.18).

Thus, constructs not only need to be unravelled or deconstructed, as Todd suggests, but a common language needs to be agreed or developed between professionals if there is to be real and meaningful collaborative relationships between education, health and social care services.

Lord Laming’s original call for a common language for all agencies, and more recently to ‘create a shared language,’ is perhaps needed if effective collaboration
is to be taken forward (Laming, 2009, section 5.18). Ultimately, inconsistent use of terminology can be confusing to children, parents and professionals (Robertson, 2010) and without a shared language communication and understanding are difficult. Indeed; “in the worst-case scenario they will be talking completely at cross-purposes.” (Little et al., 2003, p.4). A common language and a framework in which to understand children are perhaps required if multi-agency collaboration is to progress (Frost, 2005; Myers et al., 2004; Bertram et al., 2002).

The future of multi-agency working

There are clear difficulties, as outlined above, with regard to multi-agency working due to a whole host of interrelated factors from infrastructures, to lack of a common language through to significant conceptual differences. The literature review reveals many diverse attempts at multi-agency working; all verify its importance but highlight inherent weaknesses of current practice and policy. The importance of effective multi-agency collaboration throughout the literature research is largely indisputable and schools are central to this process. In general, the literature reviewed is consistent with regard to facilitating or inhibiting factors so what is the future for multi-agency working?

Prior to Every Child Matters (2003), multi-agency working appeared to have had little integration of infrastructure (Leadbetter et al., 2007) and that although multi-agency teams are now subsequently formed around the whole child, as opposed to the specific need, the actual issues of how the professionals work together and what is required to ensure positive working relationships still remains ambiguous. Thus, there appears to be the need for new ways of working to be developed:

The Every Child Matters document (DfES, 2003) exhorts professionals to form teams around the child and the family, but how they should work
together and what is to be taken from old practices, and what will need to be constructed as new practices, is unclear (Edwards, 2004, cited in Leadbetter et al., 2007, p.86).

Further, although Every Child Matters requires professionals to work together and share practice and tools, tensions remain. This may be due to professionals’ fear of loss of identity (sometimes deliberately protected) and of expertise, role demarcation and status, the latter often built on exclusive knowledge. Emerging from the literature are genuine conflicts and difficulties, for a whole host of reasons, within multi-agency working:

both from the different priorities that agencies establish and the different definitions of pedagogic purpose and practice that govern their work (Tett, 2005, p.159).

Certainly the undervaluing of different professionals, different perceptions of roles, responsibilities, status, information sharing and even understanding each service providers terms, etc, causes conflict. Nothing really seems to have moved on. The history of collaboration between professionals does not appear promising for several reasons. However, there is still undeniably the desire to have joined up working despite the inherent and real problems that multi-agency working brings (Robinson and Cottrell, 2005).

It is perhaps reasonable then to consider the development of a key children’s services conceptual framework and a common language which professionals can utilise collaboratively. Professionals have surely to find a route or a framework to ensure appropriate, consistent and effective ways of working together if we are to improve children’s educational outcomes and life chances. Perhaps then, it is time to consider new ways of working.
New Ways of Working

For collaborative working to move on, ‘new tools’ to respond to change are clearly required for effective practice and to challenge the ‘assumptions of practice’ that impede effective multi-agency working. Daniels et al., (2009) refers to the importance of using a framework such as Cultural Historical Activity Theory in moving collaboration forward through the analysis of how people and organisations learn new ways of practice, and how individual and organisations change. Further, Edwards (2005) advocates that that Engeström’s version of activity theory allows us to see any activity system as an open-ended learning zone where different ideas and interpretation are encouraged so that new meanings can be revealed ‘which in turn call for new responses and the development of refined conceptual tools in those responses’ (ibid, p.5). Edwards cites the example of inter agency collaboration:

A clear focus on prevention and the trajectories of the socially excluded is often new work for services which have either been isolated and marginal ... not easily collaborating across professional boundaries.... we are seeing that inter-professional collaboration and the stimulus we provide in activity theory structured workshops are helping practitioners to understand the complexities of these trajectories and to develop new ways of thinking about their practice (ibid, p.6).

In order to work collaboratively, it thus makes sense to have a common framework that all professionals across the key children’s service providers can relate to, build genuine understanding and utilise effectively for the benefit of the child. The want for a framework that unites professionals across education, health and social care in a shared understanding of need, and one that addresses deep seated cultural and assumptional differences, is thus particularly pertinent.
In the earlier sections, it was seen that the various professional theoretical understandings held can impact negatively on interventions and thus on outcomes for children. As we have seen too, there are many different ways in which to understand or conceptualise a child’s individual needs. Different professionals have different frameworks which are often driven through pathology or a social focus, e.g. there are psychosocial and cognitive behavioural models, as well as diagnostic or deficit models (see Corcoran and Casebolt, 2004), used to inform interventions. Frost (2005) makes reference to the different social and medical models with regard to professional interpretations of particular needs, as well as professional differences in interpretation such as victim centred and offender centred models of interventions. Such frameworks utilised are often discipline specific and can be confusing. They are not necessarily understood by external collaborating professionals.

Several conceptual frameworks are already used within the core children’s services and include that of need, special educational need, mental health and well being. However, such frameworks tend to be dominated or owned by particular groups and thus are not really bought into by the other corresponding professionals. Within health for example, models tend to be deficit in orientation, encourage labelling, involve symptoms, and utilise expertise and knowledge to the detriment of other professionals (Todd, 2007). Mental health, for example, is characterised by the dominance of a medical model emphasising disease and pathology. Mental health within an education setting refers to spiritual, social and emotional dimensions and has no relevance to a predisposing disorder or disease. It is precisely the lack of clarity or confusion about meaning and significance of different terminologies that can often impede communication and lead to misunderstandings. As Little (2003) states:
When one professional talks to another about a child at risk, there is likely to be some misunderstanding and in the worst case scenario they will be talking completely at cross purposes (p.4).

As seen earlier in the chapter, previous Government policy initiatives attempted to address the organisational barriers between professionals by creating structures (such as school-based teams) within which they can collaborate. However, they do not ensure that professionals from different backgrounds will understand children’s difficulties in the same way, identify the same children as in need of intervention, or see the same interventions as appropriate.

The organisation and cultural difficulties associated with multi-agency working often interact. Culture within an institution for example can be shaped by the organisation. Within this research, there is little I can do about the organisational factors that are inherent within the core children service providers and thus are really beyond the remit of this study. However, the key cultural difficulties regarding effective multi-agency working, such as professional conceptualisation and language, could be worked through. Thus the concept of ‘risk,’ accompanied by the linked notion of ‘resilience,’ may be helpful in this situation. The risk and resilience framework cannot solve difficulties relating to organisation but could serve as the mediating artefacts, with regard to the aforementioned Cultural Historical Activity Theory to bring about cultural change.

Having a common language and conceptualisation, used by key children’s service professionals may be the very ‘new tools’ required to support multi-agency collaboration. The risk and resilience framework may well thus be of use as it may provide a means for conceptualising children’s difficulties across education, health and social care service providers and thus may serve to improve the effectiveness of multi-agency working.
The risk and resilience framework

Why the use of the risk and resilience framework when others are available within the domain of key children’s service providers such as the Common Assessment Framework (CAF), well being and solution focussed approaches?

At the time of this research, the CAF process was in its early days having been piloted within the Local Authority in 2006 for roll out in 2008. I was not fully trained in the CAF process and there was no evidence of its usefulness. Unlike the risk and resilience framework, the CAF had no solid research basis of reliability and validity. It was not empirically validated:

systems are generally absent at both local and national level to provide evidence for the sustainability or otherwise of such improvements and of any longer-term benefits. (Easton et al., p5, 2010).

I also considered using a solution focussed model, developed in America by Erickson, De Shazer, Berg & O’Hanlon (Rhodes, 1993). The emphasis is on building solutions rather than solving problems. Such an approach may well have been of use. However, the solution focussed model has a grounding in family therapy and, as such, may be considered to be ‘owned’ by social care although it crosses health through psychology. One of the reasons for using the risk and resilience framework lay in its apparent neutral status across the key children’s services. As with the CAF, the lack of a robust evidence base of solution focussed approaches as to effectiveness was another prime concern (Woods, K. et al., 2011).

I explored too, the possible use of the well being framework. However, the “ambiguity surrounding definition, usage and function of the word ‘wellbeing’” is significant”(Ereaut and Whiting, 2008, p.1). The latter refer to the different well being discourses e.g. medical, sustainability, holism and philosophy and suggest; “… wellbeing acts like a cultural mirage: it looks like a solid construct, but when we approach it, it fragments or disappears (p.5). The different usage of well being
across key children’s agencies clearly has implications: “inevitably different
groups will be constructing meaning in ways that makes sense to them - and in
ways that enable their own processes and objectives” (ibid. p17).

With the above deliberations in mind, I considered that the risk and resilience
framework may serve as an effective means for translating different service
constructs and values, etc, into a neutral cross-disciplinary concept that may
promote more effective multi-agency workings, to the benefit of children and
families. The risk and resilience framework is a solid one. It has a theoretical
grounding which can be applied to a practical setting and is based on significant
empirical evidence (Jenson et al., 2012). As with Croom and Proctor (2005), I
wanted to come away from “predetermined prescribed frameworks [and] “the
hegemony of professional knowledge” (p.123) and ensure that I utilised a
framework that capitalised on parent and professionals skills, knowledge and
understanding. This, combined with factors of empirical evidence and neutral
ownership, supported the choice of the risk and resilience framework.

The difficulties evidenced above, with regard to effective multi-agency working,
can possibly be transcended through the use of a risk and resilience framework, as
it is one that is readily intelligible and accessible by all service providers.
Furthermore, it is not strongly associated with any one professional body or group
for it to become ‘politicised’ medically, educationally or from a social care
perspective. It is not owned or dominated by anyone group of professionals,
indeed there are several research examples of education, health and social care
utilisation (Atkinson et al., 2009; Rutter, 2006, Croom and Proctor, 2005; Corcoran
and Casebolt, 2004; Hermann, 2002; Noam and Hermann, 2002.).
Risk and resilience is thus a relatively neutral framework. It does not specify what should count as successful outcomes, but once these outcomes are specified, it offers a means of defining risks in relation to these factors. It therefore promotes inter-professional debate on what counts as successful outcomes, but relies on openly accessible data to identify risk. There are three main components within the framework – risk factors, protective factors and resilience. The history of how this framework developed and structure of risk and resilience is outlined below.

A brief history of the risk and resilience framework

The risk and resilience framework was originally utilised within the disciplines of education and psychology as a way of understanding individual behavior (Corcoran and Casebolt, 2004). The framework considers risks, or factors that can contribute to a particular problem, and protective factors, internal and external resources that may protect an individual from the risks, which interact to promote an individual’s resilience or coping ability to function ‘adaptively despite life stressors’ (ibid). A later and more developed model of the risk and resilience frameworks relates to ecology – the micro, meso and macro systemic forces (Bronfenbrenner, 1989). Micro level forces refer to individual factors such as temperament, health, intelligence and family. Meso refers to social environment factors, for example, neighbourhood, school and community resources. Macro refers to the wider forces of poverty, discrimination and employment, etc.

Risk factors

The international, cross cultural, epidemiological and longitudinal studies of what constitutes a risk are both vast and complex. Risk factors may be defined as, “influences, occurring at any systemic level that threaten positive adaptational outcomes” (Waller, 2001, p.292). Risk factors include genetic, biological, psychological, environmental or socioeconomic, socio-environmental and socio-
psychological aspects that are associated with increased risk of maladjustment (Schoon, 2003; Luthar & Cicchetti, 2000; Masten et al., 1990; Bronfenbrenner, 1989). Its constitution can be defined within different dimensions including individual, familial, societal. Indeed, risk factors can be “multidimensional, interactive and multiplicative and should be viewed as a continuum (Howard et al., 1999, p.308).

Risk factors may be identified from the perspective of micro, meso and macro levels and their corresponding interactional and inter relationships (Corcoran and Casebolt, 2004). There is also an ecological perspective in explaining risk which relates in principle to the interactions between the biological and psychological characteristics of the individual and their respective environmental and community influences and interactions.

Risk factors include characteristics of individuals and families, social contexts or the interactions between persons and their environments. Poverty, familial dysfunction, adverse living conditions, and preponderance of parental mental health difficulties, etc, are thought to significantly increase risk levels within children so that their life chance are diminished in terms of education, health, income and social contribution (Smith and Carlson,1997). In essence, risk factors can lead to chronic life situations beyond the control of the child. Poor outcomes can include drug taking, gang involvement, anti social behaviours, criminality, lack of engagement with school and educational failure.

Risks, which can be cumulative, are often predictive of adult dysfunction and can lead to health difficulties (both physical and mental), criminality and unemployment (Schoon, 2003). They may lead to further familial poverty and illiteracy.

Poverty is considered to be a significant risk factor with regard to teenage pregnancy, drug abuse and school failure (Swadener and Lubeck, 1995). Poverty
in childhood is thought to be one of the most “consistent predictor of dysfunction in adulthood” (Doll and Lyon, 1998, p.355) and is a predominant factor in educational failure (Schoon et al., 2004).

Table 5 below provides a summary of the major risk factors determined from the review of literature and categorised into micro, meso and macro factors for ease of reference. Their impact is varied depending on the individual circumstance of the child and the interlinking relationship that child has within their development

**Table 5 Common risk factors cited by researchers** (Gutman et al., 2010; Corcoran and Casebolt, 2004; Statham, 2004; Orthner et al., 2004; Waller, 2001; Masten and Coatsworth, 1998; Silliman, 1998; Smith and Carlson, 1997; Fraser 1997; and Grotberg, 1995).

<table>
<thead>
<tr>
<th>Micro</th>
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<tbody>
<tr>
<td>Domestic violence</td>
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<tr>
<td>Poor educational attainment</td>
<td></td>
</tr>
<tr>
<td>Minority ethnic</td>
<td></td>
</tr>
<tr>
<td>Looked After Status</td>
<td></td>
</tr>
<tr>
<td>Special Educational Needs</td>
<td></td>
</tr>
<tr>
<td>Refugee / asylum seeking status</td>
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<tr>
<td>Poverty</td>
<td></td>
</tr>
<tr>
<td>Parental criminality</td>
<td></td>
</tr>
<tr>
<td>Marital discord Family dysfunction</td>
<td></td>
</tr>
<tr>
<td>Foster placement Large families</td>
<td></td>
</tr>
<tr>
<td>Poor / overt parental discipline</td>
<td></td>
</tr>
<tr>
<td>Poor social skills</td>
<td></td>
</tr>
<tr>
<td>Early sexual experience</td>
<td></td>
</tr>
<tr>
<td>Teenage mothers</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Low intelligence</td>
<td></td>
</tr>
<tr>
<td>Low self esteem</td>
<td></td>
</tr>
<tr>
<td>Physical disability Poor health and mental health</td>
<td></td>
</tr>
<tr>
<td>Stress</td>
<td></td>
</tr>
<tr>
<td>Death of close relative</td>
<td></td>
</tr>
<tr>
<td>Substance misuse</td>
<td></td>
</tr>
<tr>
<td>Trauma / catastrophic life events</td>
<td></td>
</tr>
<tr>
<td>Maltreatment Abuse Bullying</td>
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<table>
<thead>
<tr>
<th>Meso</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Discrimination</td>
<td></td>
</tr>
<tr>
<td>Social isolation</td>
<td></td>
</tr>
<tr>
<td>Poor education</td>
<td></td>
</tr>
<tr>
<td>Drugs High use of alcohol</td>
<td></td>
</tr>
<tr>
<td>Antisocial behaviour</td>
<td></td>
</tr>
<tr>
<td>No extended family</td>
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</tbody>
</table>
Risk factors are rarely isolated experiences and thus are often clustered. It is often the accumulation of risk factors that can lead to poor outcomes. For example, many children may be exposed to poverty but some children nevertheless do well. However, poverty, and experience of death of a relative, poor mental health of the parent and subsequent use of drugs and alcohol may be predictive and result in a child having poor life outcomes:

Many investigators have taken a broader perspective when examining the risk factors that impact on children’s development. To accomplish this, researchers may use regression analyses with a large set of risk variables. Alternatively, a number of researchers have employed a cumulative risk model that incorporates a set of risk factors created by aggregating information about stressful life experiences or risk indices. In both instances, the cumulative risk score is calculated by dichotomising each condition into two groups, representing the presence (1) or absence (0) of an event or risk, and then adding all of the resultant scores. In general, cumulative risk models indicate that the more risks the children experience, the worse their developmental outcomes (Gutman et al., 2010, p.16).

**Protective factors**

As noted earlier, exposure to adversity does not always result in poor life or poor educational outcomes. Often it is the presence of protective factors that lessen or compensates for the risks faced (Gutman et al., 2010). Protective factors are attributes that people have, acquire or experience that militate against adversity.
Table 6 below indicates the common protective factors that were often cited by researchers within the review of literature.

Table 6 Common protective factors cited by researchers (Stein, 2005; Masten, 2001; Luthar & Cicchetti, 2000; Masten et al., 1990; Werner, 1990; Garmezy 1988, 1973; Rutter, 1987.).

<table>
<thead>
<tr>
<th>Micro</th>
<th>Positive self esteem</th>
<th>High self regard</th>
<th>Humour</th>
</tr>
</thead>
<tbody>
<tr>
<td>High cognitive ability</td>
<td>Talent Accomplishment in tasks</td>
<td>Positive experiences</td>
<td>Secure base</td>
</tr>
<tr>
<td>Sense of belonging</td>
<td>Friendship</td>
<td>Sense of identity</td>
<td>Sociability</td>
</tr>
<tr>
<td>Family resilience</td>
<td>Positive attachment to a significant adult</td>
<td>Social support</td>
<td>Warm, caring relationship</td>
</tr>
<tr>
<td>Parental advocates</td>
<td>Self efficacy</td>
<td>Academic attainment</td>
<td>Positive school experience</td>
</tr>
<tr>
<td>Good education</td>
<td>Effective schooling</td>
<td>Good health</td>
<td>Easy temperament</td>
</tr>
<tr>
<td>Emotional literacy</td>
<td>Competent parental skills</td>
<td>Positive reinforcement</td>
<td>Resistance to oppression</td>
</tr>
<tr>
<td>Family cohesion</td>
<td>Personal responsibility and autonomy</td>
<td>Creative problem-solving skills;</td>
<td>Social competence; an ability to tolerate frustration and manage emotions; a feeling of personal control over ones life and self-Confidence</td>
</tr>
<tr>
<td>Optimistic outlook; Persistence in the face of failure; Experience with self-mastery;</td>
<td>An ability to seek out support</td>
<td>Faith</td>
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</tbody>
</table>
It is the interaction between risk and protective factors, across micro, meso and macro levels that determine resilience (Waller, 2001). Protective factors can ameliorate the adverse effect of risk factors and can “buffer exposure to risk” (Jenson and Fraser, 2005, p.6). This thus brings us to the concept of resilience which is may be seen as; “the outcome of a process that takes into account level of risk exposure and the presence or absence of protective factors (ibid pp.8-9).

**Resilience**

Early research on resilience developed from work in the psychiatric and clinical psychology field (Atkinson, *et al.*, 2009). The theoretical concept of resilience first came to prominence through Garmezy’s study (1974) of children of schizophrenics who appeared to have normal development despite their adverse situations. His research was linked to the psychopathology paradigm. Other longitudinal studies, focussing mainly on specific populations followed, including studies by Werner and Smith, 1988; Anthony, 1987; Garmezy and Rutter 1983). In these later studies, the subjects were children and adolescents who were classified as being at risk of psychiatric disorders, delinquency and other negative life outcomes because of a variety of individual, family and environmental factors. Instead of focusing on individual deficit, the new approach focused on individual strengths and, thus,
the concept of resilience emerged in the psychological literature (Howard and Johnson, 1999).

Resilience has varied definitions and conceptualisations since the early 1970s (Masten, 2001; Luthar et al., 2000; Masten et al., 1990). It may be defined as the possession of skills, attributes and resources over time, space and to varying degrees (Luthar & Cicchetti, 2000; Rutter, 1999, 1990; Masten et al., 1999).

Resilience can be defined as:

the multidimensional, dynamic process of positive adaption to adversity. It is the ability to bounce back from adversity and change and involves internal and external adjustments to risks (McGrath and Noble, 2007, p.10).

Resilience has a number of slightly different definitions, but the one I propose to use for this study is one who, “having endured adversity... continues to function reasonably well despite continued exposure to risk” (Gilligan, 2000, p.37).

Resilience can have both a social or constitutional origin. Social aspects include levels of family support, positive experiences at school, supportive friends, etc. Constitutional factors include gender, intelligence, and health. Martinez and Williams (2011) refer to resilience as a dynamic process of interaction between sociocultural contexts and the agency of developing individuals and argue that it lies in the relationship between the individual and the sociocultural context.

The studies outlined above have impacted on educational and social work policy (Craig, 2007; Daniel, 2006; McNamara, 2000; Doll & Lyon, 1998). More recently, resilience theory has been included in new approaches to post traumatic stress disorder and mental illness (McCormack, 2007 cited in Atkinson and Martin, 2009; Edward & Warelow, 2005).
The review of literature indicates four main ways of reducing risk and building resilience (Fraser, 2004; Smokowski, 1998; Masten, 1994): Through a) direct intervention such as working on the cognitive development in order to build higher self esteem; b) reducing stressors through parenting courses; c) increasing services and resources to vulnerable communities e.g. Sure Start and d) mobilizing protective processes e.g. ensuring there are supportive adults made available to children at risk.

Building resilience to adversity can buffer the risk factors and go towards ameliorating poor outcomes but is often a complex process due to the various interlinking factors and multi dimensional relationships involving the individual, family, community, environment and culture of any given individual at any given time. However, the ultimate importance of a specific intervention relating to resilience building is that it has the potential to alter the life trajectory of a child or young person and can be transformative.

**Utilisation of the risk and resilience framework**

At its simplest, the concept of risk, protective factors and resilience offers a way for professionals across the key children services to identify individuals who may go on to experience poor educational outcomes at a point well before those outcomes become apparent, and may direct attention towards the factors where intervention may be necessary. The literature on risk and resilience offers a reasonably robust framework which professionals can use to inform their practice with children who are likely to experience poor educational outcomes. The risk and resilience framework is underpinned by empirical, academic and evidence based inquiry and thus there is a growing credence for its use (Fraser, 1999).

The framework may be considered as neutral, in so much as it is not owned by any professional group, and offers a common language within which differences
of opinion can be debated and made more explicit. The framework offers a very distinctive conceptualisation of the child yet it is one that is easy to apply as it is straightforward. It allows for different perspectives to be brought together. Risk factors can be seen from various perspectives according to profession. For example, the social care professional may well focus on familial issues, health on biological and school on educational issues. The framework allows the perspectives to come together and a unified strategy of support proposed.

It is important to understand how professionals working with children in disadvantaged circumstances actually understand the risks to which those children are subject, the extent to which they share common understandings, and the implications of those common or different understandings for the possibility of co-ordinated action. The definition of risk itself is required within a multi-agency setting as risk means different things to different professionals. As Croom and Proctor (2005) found ‘social services tended to interpret ‘risk’ as ‘risk of child abuse’. Health professionals tended to interpret risk as the increased likelihood of developing problems/disorders and with regard to education, the notion of ‘risk did not appear to be an integral part of school language’ (p.120). Thus the need and importance for professional training:

All practitioners recognised that the underpinning theory of risk and resilience had not been an integral part of their training but that it was essential if practitioners were to use the framework effectively (ibid, p.120).

It is also important how professionals understand the concept of resilience. Resilience involves constitutional and environmental factors and practitioners are encouraged to look for and enhance children’s strengths as they appear at the point of intervention (Croom and Proctor, 2005; Little et al., 2003; Schofield, 2001).
The risk and resilience framework is one that all professionals across health, education and social care may find of use. The concept of risk and resilience has increasingly emerged as a construct for conceptualising health and social problems (Schoon, 2005; Corcoran and Casebolt, 2004; Schoon, 2002; Fraser 1999; Gibbs and Gambrill, 1999; Howard and Jenson, 1999). To understand social problems and subsequent intervention plans, practitioners have to address both the risk and the ways of developing future protection from risks. Conceptualising problems and intervention strategies within a risk and resilience framework has the capacity to be a significant construct for conceptualisation, assessment, policy and informing intervention across the key children’s services. (Corcoran and Casebolt, 2004; Fraser et al., 1999; Howard & Jenson, 1999). Indeed, as Little (2003) states:

The starting point should always be an analysis of risk and protective factors to give a prognosis of the child’s future development. This analysis can be translated into a statement of the child’s unmet needs. This will provide a platform for decisions about how and when to intervene. Whatever the circumstances, it makes sense to foster the child’s inherent strengths and resilience, and where impairment exists to bolster their coping strategies (p.22).

**A rationale for using the risk and resilience framework within a multi-agency setting**

Put simply, the risk and resilience framework may facilitate collaborative work by professionals identifying risks that may lead to poor educational outcomes and to identify their respective strengths or protective factors which can protect them against developing such a negative trajectory. Through collaboration and negotiation, professionals can put in place interventions that build the child’s resilience, and thus improve educational outcomes.
The risk and resilience framework is a relatively easy framework to comprehend and has an extensive research empirical base to satisfy, particularly, social care and medical practitioners’ philosophy of practice (Rutter, 1987, cited in Garmezy 1993). It is flexible and allows all professionals to address the concerns surrounding the individual child. If one states a child is at risk, one automatically asks at risk of what and this leads therefore to explicit debate for desirable outcomes. Indeed, specifying what the child is at risk of, is more productive than talking about a child being ‘at risk’ as this tells us little about the individual’s situation or ways of improving it (Little, 2003).

An example of where the risk and resilience framework has been advocated and utilised effectively across education, social services and health is that stemming from of Croom and Proctor’s research (2005) with the development of the NewCan Practice Framework which is:

designed to enable professionals from a range of agencies (health care, education, social services) to utilise evidence on risk and protective factors in child and adolescent mental health in order that they can:

- assess the child and family needs using a common evidence base and shared language to communicate across all agencies involved in the care of the child;

- enhance local capacity to respond to the needs of these children by identifying resources/services available locally which can enhance protective factors and reduce risk;

- develop a plan of intervention shared by all agencies involved in the care of the child, including the child’s contribution and that of their family/carers to the realisation of the plan.

The framework was designed to help practitioners across agencies to identify the most effective combination of universal, targeted and clinical services for each child/family and community that can be configured to respond to the risk and protective factors within the local socio-cultural context (p.113).
The above report indicated that the framework provided a common or shared language upon which to build appropriate interventions, with relevant professionals agreeing that using the risk and resilience framework was “helpful in communicating their level of involvement with client and outcome” (Croom and Proctor, 2005, p.120).

Within the conceptual framework, risk factors observed may be at a wide range of levels, micro, meso and macro. Through analysis and discussion, appropriate interventions to diminish risks, build on protective factors and accentuate resilience may be promoted in order to improve educational outcomes. Through using the framework, professionals can surface their own assumptions without ‘technical jargon’ (Salmon and Rapport, 2005) and discuss the particular child through clarity of shared conceptualisation and action.

The risk and resilience framework does not medicalise or pathologise the child. Furthermore, it builds on the strengths of the child as opposed to a pathology and problem inherent within the child. Risk and resilience can perhaps provide a theoretical and practical basis for professional to conceptualise, see the child as a whole and intervene strategically and effectively.

The risk and resilience framework is advocated for use within America with regard to “policies and services that affect high-risk children, youths, and families” (Anthony, Alter and Jenson, 2009, no page number given). Whether multi-agency work is problematic there, as here, is not the remit of this study. I have referenced it only to indicate that professionals from across the key children services are able to utilise it effectively (Jenson and Fraser, 2006; Allen-Meares and Fraser 2003; Noam and Hermann, 2002; McWhiter et al., 1998).

This study aims to look at this framework as a way forward in unifying professional concern and reconciling conceptual differences across the key
children’s services; “The framework allows a holistic approach in terms of interventions and satisfies the need for integrated service delivery” (Schoon and Bynner, 2003, p.26).

Thus, the risk and resilience framework is one that could bring professionals across education, health and social care together in order to plan effective intervention strategies for a particular child in order to improve educational outcomes. It allows professionals to use their own areas of expertise to impact on the child and allows greater understanding of each other’s roles and enables professionals to understand the specific context surrounding the individual and put in place strategies to affect improved outcomes for the future. It is a shared and coherent framework, one that has a common language and affords cooperation. An analysis of risk and resilience factors with regard to a child’s future development can equate to unmet needs and thus a shared platform for relevant interventions (Little, 2003).

Traditionally, risk and resilience research has tended to be large scale, quantitative longitudinal work. The research undertaken is innovative as it takes the framework and applies it in a very practical way within an educational setting. The risk and resilience framework may indeed bring the impetus needed to the development of policies aimed at promoting the well being of children at risk of poor educational outcomes through effective multi-agency collaboration if used jointly by education, health and social care (Schoon and Bynner, 2003).
Chapter 3 Methodology

An overview

The chapter focuses on the approach undertaken for this research and revisits the research questions. This is followed by the choice of and rationale for methods chosen and a description of how data was collected and analysed. The ethical issues pertaining to the research and trustworthiness of methods deployed are examined, as are the limitations of the methods used.

Context

The review of literature provided a framework for the research relating to multi-agency working. The review indicated that professionals working with children within an educational context often had different conceptualisations of those children built on frameworks specific to their profession. For example, frameworks could be based on pathology, on a prescribed social understanding or through using a diagnostic model (Corcoran and Casebolt, 2004). Such discipline specific frameworks can often be misunderstood by external collaborating professionals. This in turn can lead to lack of coordinated and coherent provision and / or appropriate intervention.

The complexities of multi-agency working are well documented and organisational and cultural barriers can all impact on effective collaboration (Todd, 2007; Robinson and Cottrell 2005; Hudson, 2002). This research seeks to explore multi-agency working amongst professionals across the key children’s services. Data collected is from a variety of professionals working within a secondary school in an urban area.
**Approach**

This research study is built on a social constructivist paradigm, uses qualitative methodology and is primarily based on case study design. A field trial is undertaken within the course of the research.

The research is concerned with the extent to which professionals working with school-age children in a specific urban context, populated by students who came from disadvantaged backgrounds, share common understandings of the risks for poor educational outcomes to which those children are subject. It is intended to ascertain how far different professionals working with a common cohort of pupils understand the risks to which they are subject in similar ways and how these understandings impact upon any interventions they propose or undertake. Finally, the research seeks to see if a common framework can be used, such as the risk and resilience framework, within a school multi-agency setting involving professionals from across the key children’s services.

**Research questions**

The data collected for this study seeks to answer the following research questions; a) What understandings of risks for poor educational outcomes do professionals from different backgrounds, but working with the same children, have? b) How congruent with each other are those different understandings? c) How congruent are they with understandings of risk in the research literature? d) How do these professional understandings shape the interventions with children that different professionals propose, and what are the implications for the possibility of coordinated and effective interventions? e) Is the risk and resilience framework a viable one to utilise by professionals from across the key children’s services, in order to develop a shared understanding of the child and thus ensure coordinated and effective interventions?
**Background**

The research is focused on an inner city secondary school within the northwest of England. It focuses on a group of professionals who all have a knowledge and understanding of the local policies and practices that relate to this particular school, as well as a corresponding professional involvement. The research also involves practitioners, the practitioners, working with a specific cohort of children at the school identified as at risk of poor educational outcomes. The school provides a common reference point for all professionals involved and they are able to talk about the pupils at the school in an informed manner.

**The role of the researcher**

I was an acting Deputy Headteacher (Inclusion) / SENCO at the school at the centre of this research and thus had access to all data pertaining to the children identified for specific reference and analysis.

However, I nonetheless sought permission from the Headteacher with regard to the issue of confidentiality pertaining to data collected and its utilisation.

I had two significant advantages in that; i) the professional role played by me enabled crucial insight as to who to contact internally and externally in relation to the case study school and pupils involved; and ii) the professionals were known to me and therefore relatively easy to contact and access.

Knowledge of personnel, ease of contact and access to relevant documentation certainly made the research relatively easier to undertake compared to someone external to the case studied. However, as an external researcher, other professionals may have been selected for the research undertaken; the external researcher would not necessarily have ‘preconceptions about issues’ (Robson, 2002) and; an external researcher may have elicited different responses from the participants.
Nevertheless, as with case study and, indeed, as required for all qualitative research, I strove to ensure that methods utilised were accessible to others and rigorous, i.e. “systematically grounded in justifiable and coherent principles” (Robson, 2002, p.537).

**Ontology**

The research process itself is located within in a social constructivist paradigm. Constructivism refers to the process whereby the cognitive structures that shape our knowledge and understanding of the world develop through the interaction of both environment and subject. Robson states that reality is socially constructed (2002, p.27). The research participants, in this case the range of professionals across the education, health and social care services within a school context, are viewed as “helping the researcher to construct the reality with the researcher” (ibid, p.27). The research undertaken considers how professionals construct their understanding of a child and how these constructs are surfaced. It explores ways in which constructs can be changed or subsumed into a structure.

**Research methodology and design**

In general, the research methodology utilised for the purpose of this study is that of qualitative research. Qualitative methodology gives credence to participant accounts as opposed to generalisability and reliability. The researcher must ensure validity of participant response through ensuring accounts reflect the participant’s belief. The main aspects of qualitative methodology used within this research involve data collection and analysis gathered through interview and questionnaire processes, and school held documentation. Methods of interpretation used in the research include thematic coding and content analysis. Responses from
participants were collated and analysed from an individual, and collective, perspective. Data was compared and contrasted, with similarities and differences manually recorded and then analysed individually and collectively amongst professional groups and in relation to five pupils.

The design of this research is that of case study. The unit of the case study is the school and the pupils are the sub units of the school. The research is based on this single school and focuses on the professionals associated with that school. It explores a phenomenon, that of how professionals conceptualise the children they work with, and uses a variety of qualitative sources to understand and explain this.

The components of this particular case study involves ; a) eliciting general professional views of the children worked with within a particular school, and the corresponding community context; b) eliciting practitioner views and constructs with regard to a specific cohort of pupils; c) undertaking case studies of five representative pupils; and d) undertaking a field trial with regard to an initial exploration of the risk and resilience framework through a multi-agency meeting held at the case study school.

A key aspect of this research concerns establishing an understanding of how professionals construct their view about children and how they translate this into action. This is a key case study research method:

   an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used (Yin, 2003 , p.23).
The context and content of this research fits well with this definition and, similarly, that of Bassey’s (1999). The latter refers to an educational case study as an empirical enquiry conducted; a) within a localized boundary of space and time; b) into interesting aspects of an educational activity, or programme, or institution, or system; c) mainly in its natural context and within an ethic of respect for persons; and d) in order to inform the judgements and decisions of practitioners or policy-makers.

This case study may be viewed within the above corresponding parameters; i.e. a) it focuses on an inner city school; b) it looks into different professional conceptualisation of children’s difficulties; c) it collects evidence from professionals working with specific pupils; and d) considers the utilisation of a framework to ensure joined up and coherent interventions to improve pupil educational outcomes.

Bassey (1999) argues that the data collected must allow the researcher to explore significant features of the case, create plausible interpretations, test for trustworthiness and thereafter construct and convey in a convincing manner a worthwhile argument. Ultimately, this is what the research undertaken will aim to undertake.

Part of the research involved a small activity with a group of professionals using the risk and resilience framework. The research could thus be considered as a hybrid of case study and action research due to the role of the researcher as a practitioner within the context of the research undertaken. However, given the limitation of one actual case, it is best considered as a field trial.
An empirical review of literature

The information stemming from the review of literature with regard to multi-agency collaboration, risk, protective and resilience factors and later the risk and resilience framework, was utilised to provide a context, a set of ideas and concepts that I could then utilise to make sense of the data. I manually recorded commonly emerging evidence from the literature which thus allowed me to establish a set of common difficulties relating to multi-agency working arising from Atkinson et al’s (2007) comprehensive review of literature (Appendix 2) and agreed risk, protective and resilience factors from a variety of researchers. These are listed in Appendix 3. This process provided a solid framework in which to compare whether participants views directly corresponded to that in the literature or not.

Secondary analysis of school held data

A wide range of case study school related data was collected in order to enable me to identify pupils at risk of poor educational outcomes. Data sources used were primary and secondary school-held documents. The data collected at transition to the case study secondary school provided an evidence base for the researcher to identify children at risk of poor educational outcomes, as informed through the review of literature. This original data collection was utilised to thereafter select five pupils to act as case study children at a later stage in the research.

Interviews and questionnaires

The interviews and questionnaires, in essence, provided the two key components with regard to case study design, i.e. eliciting practitioner views and constructs with regard to a specific cohort of pupils.

Firstly, sixteen semi structured interviews were undertaken with lead children services professionals and, secondly, 29 questionnaires were then completed by 18 practitioners of 5 case study pupils. This is described in more detail in the section below.
Child case studies

Data was collected through the above questionnaires and school records were collated and analysed, and used as the basis of child case studies. These were undertaken in order to establish how professionals, henceforth referred to as practitioners, worked with individual children. Data was analysed to determine their explicit or implicit conceptualisation of the child and to establish areas of commonality or differences within the subsequent interventions provided. The questionnaires sought to ascertain if practitioners’ actions are informed by professional conceptualisations or if other factors shaped the actions they take.

Field trial

During the course of the research, an opportunity presented itself to use the risk and resilience framework to identify needs and establish strategies and provision with reference to a specific pupil highlighted at risk of poor educational outcomes. This field trial was based on an initial exploration in using a risk and resilience framework and provides the final component to case study methodology, i.e. to inform the judgements and decisions of actual practitioners (Bassey, 1999).

The methods used for data generation in relation to this research are summarized, for ease of reference, in the table below:

<table>
<thead>
<tr>
<th>Table 7 Method of data collection – what sources were used</th>
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<tbody>
<tr>
<td>Method of Data Collection</td>
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<tr>
<td>---------------------------</td>
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<tr>
<td>Review of literature to extract data to compare to participant responses</td>
</tr>
<tr>
<td>Secondary data</td>
</tr>
<tr>
<td>Interviews</td>
</tr>
<tr>
<td>Questionnaires</td>
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<tr>
<td>Child Case Studies</td>
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<td>Field trial</td>
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Rationale for methodology selection

Case study design
This thesis explores the cultural and organisational difficulties of multi-agency working within a local school where I worked, where some children with complex social, economic and cultural difficulties did well as others did not. Through my inclusion role, issues were evident with regard to effective multi-agency relationships and collaboration, often reducing the effectiveness of collaborative practice and impeding positive educational outcomes for pupils. Professionals appeared to have their own understandings of children, worked within their own organisational cultures, leading to various misunderstandings. This environment indicated a lack of a common framework in which to understand children. Case study design was chosen to explore these issues as it is useful method for investigating real life and contemporary events (Yin, 2003). The school at the centre of this research provides a real life event. The school is where I worked at the time of the field work collected and thus provided a contemporary context. It is the how and why questions within a real life and contemporary context that underpin case study (Yin, 2003a). Hence its use.

Use of literature
The standard review of literature undertaken gave a solid framework, perspective and justification for the research undertaken. The literature indicated that there has been a substantial amount of research into what factors constitute a risk and what the protective factors are relating to resilience. Risk factors may, for example, include; family dysfunction, abuse and community issues such as drugs, violence and lack of resources. Protective factors may include temperament, strong adult advocate and having a specific talent (Schoon et al., 2004; Luthar et al., 2000; Silliman, 1998; Smith and Carlson, 1997; Grotberg, 1995, Swadener and Lubeck, 1995).
In terms of resilience, factors may be considered from a variety of perspectives, from individual, cultural to environmental (Bernard, 2004; Ungar, 2004; Najman et al., 2003; Werner and Smith, 2001; 1992; Howard and Johnson, 1998; Masten, 1994). The literature also formed part of my empirical work as it allowed me to establish a framework that I could compare later research participant responses to. From the literature, I recorded the most regularly appearing and commonly agreed set of common risk, protective and resilience factors and directly compared them to those identified by and collected from the participants, both professionals and practitioners (see Appendix 3). These findings are reported and discussed later in Chapters 4 and 5.

The information gathered gave me a framework in which to define and understand the risks that pupils may be subject to and the factors that may be protective. The review of literature drew together information of studies pertaining to definitions and understanding of risk within an educational context, of risk, risk indicators within an urban environment; and the concept of the risk and resilience framework. It helped to inform me of what to look for in the data and make sense of it.

**Secondary analysis of data**

A variety of primary written materials utilized within this qualitative research were useful sources of data. I used minutes of meetings, letters, and aspects of medical records that did not breach confidentiality and personal files. “Particular contexts generate specific types of document” (Robson, 2002, p.351). I used documents that related to pupil records relating to attendance and exclusion data, academic records, free school meals and other related school information. Documentation from transition records, and thereafter pertaining to the transferring Year 7 cohort over a period of 18 months, was thus collected and analysed. The data provided a wealth of information pertaining to the year group
and was easy to access given my SENCO / senior leadership transition role within the school.

The information enabled me to identify pupils who were at risk of poor educational outcomes in relation to the review of literature undertaken relating to risk. Information collected contained all transition data; e.g. Key Stage 2 SATs results and teacher assessments; attendance records; address and postcode; special education needs information; Looked After status; refugee and asylum status, behaviour concerns; academic progress records; reports and case reviews with professionals involved with the child; and further confidential information received at and after transition such as home life and issues pertaining to child protection. From the cohort of pupils identified as at risk of poor educational outcomes I then selected five to be case study children. These pupils were selected on the grounds that they reflected the different range of difficulties that the school regularly worked with and who had a high level of multi-agency involvement. Thus, pupils chosen fell into the at least one of the following categories – Looked After, Refugee / asylum seeking, free school meals, behavioural, social and emotional difficulties or other special educational need and had at least 2 external professionals involvement from across the key children’s services. Five such children were thereafter randomly chosen as case study children.

**Interviews and questionnaires**

Determining specific professional views of children in terms of their understanding of risks relating to poor educational outcomes was a key component of this case study methodology. The use of interviews and questions provided the bulk of the data and thus a greater emphasis is given to the rationale behind this use of qualitative methodology.
Interviews

I identified those professionals who were representative of the key children’s services who worked closely with the case study school. This was determined through my own knowledge of the school and the most common professionals I dealt with on a regular basis in the capacity as an Inclusion Deputy Headteacher / SENCO. Of the twenty I identified, 4 proved to be quite difficult to contact and, for reasons of practicality, 16 were thus interviewed. These key professionals, all either worked with pupils within the school directly, managed those that did within the school or had a direct strategic role within the district where the school was located.

Interviews were undertaken to explore professionals’ conceptions of risk and poor educational outcomes, their congruence of understanding and any subsequent intervention strategies implemented. The interviews provided an opportunity to explore conceptualisations relating to professional background as well as any emerging idiosyncrasies.

Having established a theoretical basis within the review of literature relating to risk, protective factors and resilience, I aimed to establish actual, understanding, perspective and provision through senior practitioners’ discourse. The interviews would allow me to establish if there is a common understanding of what risk is in relation to professionals working within the same educational context: The interviews served as a purposeful way to look at areas of commonality and perceptual differences when essentially they are working with the same cohorts of children within the same locality.

The sixteen interviewees were: From education; i) Education Psychologist, ii) Primary Headteacher 1, iii) Primary Headteacher 2; iv) a Behaviour Specialist; v) Outreach Support Worker 1; vi) Outreach Support Worker 2; From health: vii) a
School Counsellor; viii) Therapist 1; ix) Therapist 2; x) a School Nurse and xi) a Clinical Psychologist. And from social care: xii) Looked After Children Specialists Worker 1; xiii) Looked After Children Specialist Worker 2; xiv) Family Worker 1; xv) Family Worker 2, and xvi) a lead Social Care Manager. They were:

interviewed specifically because they are in a position to know about the things that interest the researcher. The ‘key players’ are picked out precisely because they are specialists, experts, highly experienced – and their testimony carries with it a high degree of credibility (Denscombe, 2007, p.201).

Through the interviews undertaken, I wanted to understand; a) how professionals working with children in disadvantaged circumstances understood and conceptualised the risks to which those children are subject; and b) the extent to which they share common understandings which lead to coordinated interventions. The professionals interviewed were determiners of provision within the school either directly or indirectly.

After an initial verbal approach requesting respondent participation and a brief rationale given, appointment times were established at a venue most convenient to the interviewee (usually at their place of work, within the school itself and around their own diaries): i.e. a setting where one’s full attention could be given to the actual interview with no interruptions (Anderson, 1990). A time frame of 1.30 minutes maximum was also given.

All subsequent interviewee participants gave verbal consent within a fully informed understanding of the research purpose, why they were asked to be participants and what I intended to do with collected data. Anonymity was also assured. However, I was aware that the professional relationship I had with them may both serve to facilitate disclosure or act as an inhibitor to responses. Thus, it
was imperative to ensure complete confidentiality, promote faith in my professionalism and to be very skilled as a researcher in asking questions and eliciting responses.

I undertook all the interviews personally, face-to-face and in a consistently applied format. For reasons of reliability, it was important to achieve sameness of experience (Cohen and Manion, 1989).

**Interviews and research questions**

The interviews undertaken served as a direct way of finding answers to the research questions outlined previously. Questions posed to the interviewees (Appendix 4) were sequenced around individual understanding of the term ‘risk’, primarily with regard to poor educational outcomes, interventions undertaken and multi-agency relationships. The interviews were designed to ascertain ‘corporate’ views and conceptualisations. The interview questions were essentially sub questions relation to the overarching research questions:

With regard to the research question:

- ‘what understandings of risks for poor educational outcomes do professionals from different backgrounds, but working with the same children, have?’: professionals were asked ‘how would you define children at risk of poor educational outcomes?

- To establish ‘how congruent with each other are those different understandings?’: a variety of sub-questions were asked. These included: a) what is your understanding of the risks that children face within this specific community?: b) how do you specifically identify children who you consider to be at risk of poor educational outcomes?
Regarding ‘how do these professional understandings shape the interventions with children that different professionals propose, and what are the implications for the possibility of co-ordinated and effective interventions?’ a series of interrelated sub-questions were posed including; a) what do you consider to be the major concerns / or risks for children in your care?: b) what factors enable a child to become resilient to the difficulties / problems encountered?: c) what specific intervention strategies do you deploy to lessen risk?: d) how does your organisation build or promote resilience within children?: e) which agencies do you particularly engage with regard to children at risk?: and f) is multi-agency working and inter agency liaison effective?

The sub questions were all designed to elicit information from the key professionals in order to illuminate their conceptualisations and understanding of pupils. The interview process would give me an opportunity to explore their views and constructs of children within an educational context through their professional domain, and give insight into how their constructs related to the review of literature undertaken. Further, it would give me an understanding to those constructs and to the subsequent interventions.

**Interview rationale and process**

Semi structured interviews are widely used within flexible, qualitative designs and thus my utilisation of the interviews undertaken with the children’s services professionals (Robson, 2002). Each interviewee was asked pre determined questions with wording changed slightly depending upon the role or context of the interviewee. At all times, I had control of the interview process and thus the interviews undertaken can be categorised as a respondent interview (see Powney and Watts, 1987, cited in Robson, 2002).
Using interviews to elicit information has several advantages such as flexibility and adaptability. Furthermore, the semi structured interviews undertaken allowed the use of open ended questions so that I could ‘probe’ for answers; establish cooperation and a positive rapport:

all essential to a successful interview process and thus allowing the researcher interviewer to make truer assessment of what the respondent really believes (Cohen and Manion, 1989, p.313).

The questions for interview were carefully sequenced and five sample interviews were thus undertaken to ensure that the process was appropriate and would elicit “worthwhile results” (Anderson, 1990, p.11). I thereafter became aware of the need to alter some of the questions in order to be more precise or explicit in what I wanted to elicit from the interviewee. Some of the initial questions I deemed, due to responses given, as slightly ambiguous and repetitive. I also recognised the need to change some of the terminology and phraseology of the questions, to ensure a better understanding of what I was asking. Further, I became aware of the need to ensure precise definitions of the age of the children I was particularly interested in and incorporated this within a statement of contextual explanation prior to undertaking the rest of the interviews. On one occasion, a question was misinterpreted by an interviewee, again revealing its ambiguous nature and thus subsequently altered to ensure greater precision. In the original set of interviews, 18 questions were set. Two questions, relating to mental health and social exclusion, were taken out altogether, as the subject content was, on reflection, far too broad and off tangent, digressing from the original research questions to be of real relevance. Some questions were reworded to ensure preciseness. The data from the sample interviews were still used within the findings as the changes made to the interviews questions were merely procedural.
Interview purpose

The interview process undertaken by me was to serve three main purposes; i) to gather information, ii) to test hypotheses and iii) to use in conjunction with other methods of research undertaken (see Cohen and Manion, 1989). The questions I asked determined how the interview would be undertaken and thus the decision to undertake a face to face interview as opposed to telephone. I believed that an interpersonal interview was more likely to elicit greater disclosure on a particular subject due to the trust that is developed between interviewee and interviewer (Gillham, 2005). The flexible nature of face-to-face interviews had several advantages as it allowed me to follow up ideas, seek deeper responses and investigate feelings as they transpired through the interview. How a response was made was also detected through tone and expression and this is turn allowed me to delve further into interviewee’s beliefs and concepts. Interviews often provide ‘rich and highly illuminating material’ (Robson, 2002, p.273) and the advantages of interviewing became apparent in those that were undertaken. For example, it was easy to engage the respondent and questions could be clarified where necessary. Certainly, the process of interviewing was useful in gathering data.

Interview timetable

The interviews were undertaken over a period of nine months (November 2005 to July 2006). The interviews took place either at the professional’s own venue or within the case study school venue. The latter was at the request of the professional being interviewed as opposed to my request. The venues all serving as a convenient meeting place, had access to a private conference facility ensuring confidentiality and assured no interruptions. Thus, the professionals were all able to dedicate time to a formal interview process without the usual work-related interruptions.
The open ended nature of the questions asked were designed to reveal depth of knowledge as well as giving the interviewees the opportunity to talk at length, though these make for advantages within the interview process, they were balanced by the disadvantage of time and the process of manually recording their responses. Most of the interviewees said that they did not want to be taped due to reasons relating to confidentiality. Only one interviewee was recorded, but nonetheless I scripted the interview in fear of technical breakdown and for consistency of interview process. Tape recordings do have several advantages as it allows the researcher to focus on what is being said and one can keep the natural pace of the interview alive, as well as establishing a rapport with the interviewee. However, with the sensitive nature of the interview and possible intrusive nature of questions posed, full note-taking became the order of the day. Thus, acquiring the skill of being able to interview and record at the same time became necessary.

Where appropriate, each question was paraphrased so that I was assured that what was said was intended and at the end of each interview, I gave a summarisation in order to ‘crystallize’ what the interviewee had said and thus serving, “as a necessary perception check for the interviewer” (Anderson, 1990, p. 230). Further, at the end of each interview, the interviewees were invited to read the hand-recorded answers and were able to add or delete comments. For validity purposes, I summarised views expressed and again showed the interviewee responses given. Interviewees were asked to verify responses at the time of interview and, at the end, to add anything else that they felt was relevant. This was to ensure that their views expressed were accurate and that interviewees acknowledged ownership of recorded views. Each interviewee was thanked for their time. Full notes from the interview were subsequently word processed immediately after the interview had taken place, or at least as soon as possible. Throughout the interview process, I had a critical friend read some of the
interview transcripts and the consequential analysis summaries, again, for purpose of validity

**Advantages and disadvantages of interviews for this research**

The research interview may be defined as:

> a two person conversation initiated by the interviewer for the specific purpose of obtaining research –relevant information, and focussed by him, on content specified by research objectives of systematic description, prediction, or explanation (Carnell and Kahn, 1968, in Cohen and Manion, 1989, p.307).

Certainly there are both advantages and disadvantages to the interview process. I was able to watch behaviour; to follow up interesting responses; and be able to read non verbal cues (Robson, 2002). The interviews allowed me to gain a far greater depth of understanding compared to, for example, what I may have elicited from questionnaires. However, I recognised that interviews can be prone to subjectivity and bias on the part of the interviewer. As the researcher, it was imperative that my own thoughts and insider knowledge was kept to one side to ensure such objectivity. The benefit I had of being an insider served as an advantage in terms of knowing who and how to contact key professionals, but had the disadvantage of interviewees being perhaps more self conscious with me than with an external interviewer. However, the credibility factor did play an important role as the interviewees were at least able to feel that I had knowledge and insight into the study undertaken. As a researcher, I recognized that I really had privileged access to the interviewees and was given professional respect by them as a teacher, though not necessarily as a researcher. The time and interview accorded to me was due to my professional status only.

There were disadvantages to interviewing 16 busy professionals. These included the time spent organising the interview, preparation time for the interview,
rescheduling in the event of unforeseen difficulties and writing up notes and transcripts. I was also very conscious of encroaching on other professionals’ time, as well as using my own work time to undertake the interviews.

All of the interviewees were known to me in a professional context which made arranging the interview relatively straightforward, but it also impacted upon the relationship in terms of the interviewer – interviewee relationship. The professionals had previously known me as an associated colleague, and as a researcher, perceptions are changed. Whether interviewees are more cautious or more helpful as a consequence in this change, it was nonetheless a consideration when undertaking both the interview and in analysing emerging data. It was important that the interviewees had a comprehensive understanding of their involvement prior to consenting. It was also made explicit that the research undertaken was strictly confidential, anonymous and secure. The relationship between professional colleagues and researcher is very different from that developed as a professional colleague. Although I had the advantage of the mutual respect within one’s own professional circle, I did not have one as a researcher and this relationship had to be developed.

As the only interviewer, the quality of and actual recording of interview was relatively consistent. However, the disadvantage of manually recording the interview and the labour intensiveness of thereafter transcribing and summarising via word-processing also became apparent (Anderson, 1990). The responses were all recorded and word processed, read and re-read, significant patterns with aspects of similarity and differences duly analysed and recorded. This took considerable time and on reflection a software package may have helped in the organisation of data collected.
I recognised that certain skills have to be deployed when interviewing, for the example, ability to detect and understand non verbal cues, eliciting in depth answers, ensuring understanding of the question, highly order listening skills and demonstrating appropriate body language. It was also important, in the light of subsequent comments, from the initial interviews, made about the process being ‘terrifying’, that I was open in posture and empathetic, though at the same time detached and receptive with regard to information offered (Anderson, 1990). How nervous people were in terms of being interviewed was unexpected and certainly gave cause for concern with regard to subsequent lack of lucidity. I totally underestimated the impact that the interview process would have on the interviewees and this led to a more considered and empathetic interview process; the fact that the purpose for the research related to a PhD was viewed as ‘threatening’ to one or two of the interviewees meant I had to give greater consideration to protocols and explanation prior to interviewing interviewees after the initial sample interviews were undertaken. Some of the initial interviewees comments included: “a terrifying experience but relevant,” (School Nurse); “a very probing interview,” (Lead Social Care Manager); and a “very good interview on reasonably familiar territory” (Headteacher 1). Such comments led to a change in how the interview was thereafter conducted. For example, in a more informal, relaxed but professional manner, through specifying that the interviewees were playing a helpful role in the research process in relation to how pupils’ outcomes may be improved for the future, and by playing down the fact that this was for a PhD per se.

The emerging interview responses gave rise to triangulation of data with respect to understanding of risk, marshalled interventions and expected outcomes. Once collected, compared and contrasted, I would be able to look for congruence with the research literature; consider professional definitions and interventions and draw conclusions as to effective and coordinated interventions. The interviews
undertaken with the professionals above served to communicate their ideology, conceptualisations and perceptions relating to their professional backgrounds. Management ideology and vision was of interest but I wanted to establish if their concepts and understandings transpired at ground level. That is to say, did their vision and understanding actually operate in practice - in real life situations? As Anning (2005) states, “Beliefs are embedded in the actions of practitioners” (p.24).

I wanted to establish; a) how service level conceptualisations actually translated into practice and b) if their own or corporate theoretical understandings impacted on the day to day practice undertaken with specific children. With this in mind, it was thus necessary to establish the extent to which practitioners implemented service conceptualisation. I aimed to ascertain what shaped and informed practitioners’ specific work with children who were identified as at risk of poor educational outcomes. It was important to undertake an analysis of data that could ascertain what actually happened at ground level – the extent to which professional conceptualisation was reflected in practice or what other factors facilitated specific approaches.

**Questionnaires**

I wanted to establish; a) how practitioners’ conceptualisations were arrived at, e.g. whether through individual or corporate / professional conceptualisation? b) how such conceptualisations helped or hindered collaborative practice? c) how practitioners understood the work they do and what actually influenced their practice? d) did the different practitioners see the same child in the same way? e) was there a shared understanding amongst the practitioners working with the same child? and f) were the practitioners working collaboratively with a coordinated plan?
The interviews had taken a long time to undertake, and I, as a part-time student and with a full-time job, did not have the luxury of time. To ascertain how professional conceptualisations related to or translated in practice, information from practitioners representing education, health and social care working with specific pupils required to be gathered in an effective and efficient way. I felt that the most efficient way of collecting the data required was through the use of a questionnaire.

I thus selected 5 pupils from the cohort of pupils identified previously as at risk of poor educational outcomes. These pupils were identified through transition data and are those who provide the detailed case studies evidenced later. The pupils were chosen to reflect the different range of difficulties that the school worked with and had a high level of multi-agency involvement. Staff working with these individual children were then identified by me. The staff, from across the key children’s services, were regarded as practitioners involved with the specific individual pupil. The pupils thereafter become known as case study pupils.

**Reason for practitioner selection**

The practitioners were considered by me as significant adults in the life of the particular child. They had regular individual contact with the child and worked closest with them. Eighteen practitioners were identified and 29 questionnaires given out. NB. The discrepancy of practitioners and questionnaires is due to the fact that some practitioners, such as the school nurse, had involvement with more than one child. The practitioners associated with the case study child (and who consented to undertake the questionnaire) are listed in the table below:
Table 8  Practitioners undertaking questionnaires with case study children

<table>
<thead>
<tr>
<th>Pupil</th>
<th>Professional</th>
<th>Service Represented</th>
</tr>
</thead>
</table>
| A     | 1) Head of Year;  
       | 2) Form Tutor;  
       | 3) Horticultural Therapist;  
       | 4) School Nurse. | Education  
       |                           | Education  
       |                           | Health  
       |                           | Health  |
| B     | 5) Learning Mentor;  
       | 6) Teaching Assistants 1;  
       | 7) Teaching Assistant 2;  
       | 8) Student Support Officer;  
       | 9) Form Tutor;  
       | 10) Head of Year;  
       | 11) School Counsellor;  
       | 12) Social Worker. | Education  
       |                           | Education  
       |                           | Education  
       |                           | Education  
       |                           | Education  
       |                           | Education  
       |                           | Health  
       |                           | Health  
       |                           | Social care  |
| C     | 13) Form Tutor;  
       | 14) Behaviour Support Worker;  
       | 15) Behaviour Support Specialist;  
       | 16) School Nurse;  
       | 17) School Counsellor. | Education  
       |                           | Education  
       |                           | Education  
       |                           | Health  
       |                           | Health  |
| D     | Learning Mentor;  
       | Student Support Officer;  
       | 16) Teaching Assistant;  
       | 17) School Nurse;  
       | 18) School Counsellor. | Education  
       |                           | Education  
       |                           | Education  
       |                           | Health  
       |                           | Health  |
| E     | Student Support Officer;  
       | Learning Mentor;  
       | 17) Behaviour Support Specialist;  
       | 18) School Nurse;  
       | 18) Youth Intervention Officer. | Education  
       |                           | Education  
       |                           | Education  
       |                           | Health  
       |                           | Social care  |

Questionnaire design

I designed a questionnaire that would elicit practitioner understanding of the risks the specified pupil faced educationally and socially, the type of support given to the pupil, their concept of resilience and how representative the child is in school and within the wider community. The questionnaire, similar to the interview questions, incorporated research sub questions (Appendix 5).

The questionnaire was to ascertain from the practitioner a) their conceptions of risk in relation to poor educational outcomes; b) how they respond to such perceived risks; c) their understanding of and building of resilience, d) the
similarities and differences between practitioners in their understanding and responses; and e) if provision made is coherent, coordinated, organised and managed effectively. The questions posed clearly interlink with the overarching research questions, as specified earlier. The data collected would be compared to the extracted data stemming from the review of literature.

**Questionnaire rationale**

The questionnaire was chosen as an appropriate means of data collection due to the time limitations involving the range of professionals working with the children. A questionnaire was used in this research due to ease of administration as interviews would have been too long a process given the time constraints on professionals involved.

Questions utilised in the questionnaire were designed to achieve the goals of the research and to ensure that the respondents would give a true insight into what they did:

- A good questionnaire not only provides a valid measure of the research questions, but also gets the cooperation of the respondents and elicits accurate information (Robson, 2002, p.242).

Thus, there was a need to ensure that the design of the question elicited essential research question responses, but written in a way that respondents understand what is wanted from them and are able to respond to the questions presented:

- A questionnaire needs to be crisp and concise, asking just those questions which are vital to the research....this means that the researcher must have a clear vision of exactly what issues are at the heart of the research and what kind of information would enlighten those issues (Denscombe, 2007, p.162).

I was aware that an effective questionnaire requires discipline in the writing of questions, as well as in how the responses will be analysed. Further, that the key
points to consider within the design of questions related primarily to ambiguity and imprecision; without being able to verbally qualify what a question means, the importance of language used is imperative if data generated is to be of use to the researcher, thus “precision of wording” is important (Bell, 2005, p.139). It was also important that the questionnaire was free of jargon but at the same time did not patronise the respondent.

For the purpose of this research, the aim was to elicit comment from practitioners and thus open ended questions, with a defined space in which to comment, was the format chosen. The design of the questionnaire was important – it had to be entirely appropriate to the range of professionals undertaking it and take into account their diverse educational background and experience; from teaching assistants with no formal qualifications to those staff holding higher educational degrees.

For the questionnaire to be useful and credible, I gave careful consideration to questions, clarity of construct, purpose and typology. I also used a critical friend to try it out on, prior to a sampling activity.

The questionnaire had to be visually appropriate in order to ensure people would undertake it and of a length that would achieve purpose, and presented in a style that was non-threatening to those with little confidence in completing such a document and non patronising to those fully used to undertaking such requests. Further, the questions had to be open ended in order to elicit an appropriate response across the diverse range of practitioners, but within a defined space in order not to disadvantage those with lesser literacy leanings or less verbally expressive and thus “lower the response rate” (Anderson, 1990, p.215). In other words, some of the practitioners had their own issues with literacy and I needed to
ensure that the wording was not only easy to read but give an indication of length of response. The questionnaire was not geared for one word responses. The questions had to be sequenced appropriately to retain focus, confidence and momentum in answering as well as to ensure the questionnaire made sense. Most importantly, the questionnaire needed to be relevant to actual research questions, addressed what the researcher required, was well structured and communicated a sense of purpose to those undertaking it.

With all the above in mind, a sample questionnaire was distributed to three professionals working within the same context, involving similar but non case study pupils. The aim of the sample was to identify possible ambiguities within the text, ensure wording was appropriate and elicited relevant responses, was easily understood and highlighted any omissions. The sample questionnaire was utilised with practitioners of comparable pupils to ensure the questionnaire was workable, understood and generated relevant data. The sample was important as it indicated level of appropriateness and whether wording and format were acceptable. Further, it would indicate if any question was too difficult to understand. Analysis of data was also undertaken with the sample questionnaires to ensure responses were appropriate for data collection. The responses from the sampled questionnaire thus helped to inform the final questionnaire. The relatively simple format used and careful consideration given to the questions, alongside lessons learnt in configuring interview questions, meant that no significant revision of the questionnaire proved necessary.

**Questionnaire process and protocol**

The practitioners were individually approached by me as to whether or not they would participate in the research process. It was made clear to them that this was part of an external research project and entirely at their discretion whether to participate or not. I was conscious of the fine line between being their line.
manager (for some) and an independent researcher. All were given an outline of its purpose alongside assurances with regard to complete confidentiality. It was made clear that the questionnaire was voluntary and not obligatory. Confidentiality of responses was assured for the practitioner and for the pupil involved. I made clear to the participants that responses were for the purpose of research and not for discussion within the case study school.

Each consenting practitioner associated with the pupil identified was thereafter asked to complete the questionnaire within a two week window. Each were given the same 10 questions and answers recorded by them. Questionnaires were distributed personally by me, with the reiteration of confidentiality, anonymity and thanks. A record of who the questionnaire had been distributed to and the date of return was kept. Discreet, though active, encouragement to those exceeding the two week completion request was given by me initially, but then by a colleague, as I did not want to be seen as pressurising the respondent. The colleague was able to establish that for some respondents, actual completion of the questionnaire was delayed due to their own level of confidence and three respondents subsequently had dialogue with me to this effect. As Robson observed:

> Self completion questionnaires can be subject to response bias; for example, people with reading and/or writing difficulties are less likely to respond. These skills are not called for in the interview situation (2002, p.238).

All, however, were reassured that they had a valuable contribution to make and that levels of literacy did not matter. Indeed, it was specified by me, that they had a significant depth of understanding of the individual pupil that was particularly valuable to me as the researcher. However, this response made me question whether a face to face interview should have been the appropriate way to collect data pertaining to the pupils involved. However, this would have involved a very
lengthy process, further it would have intruded on the personal time of the practitioners involved. Although, for the managers, the interviews were, by and large, undertaken in ‘work time,’ such a ‘professional’ luxury would not have been viable for the practitioners employed by them.

Selection for child case studies

Identification of pupils for case study was based on a selection of pupils within the year cohort identified at transition as at risk of poor educational outcomes; they were identified as children who appeared to be subject to significant risks and where a range of professionals was involved. Potential case study pupils involved only those who lived within a full post code area. This was in order to be representative of the community that the school directly served, as some children lived outside the community area. For each child, data was collected regarding perceived risks, risks evident from files and background data regarding attendance, attainment, and exclusions, and current professional involvement.

The review of literature pertaining to definition of risk within an educational context helped to inform the criteria of case study pupil selection such as characteristics of individuals and families, social contexts and the interactions between persons and their environments (Smith and Carlson, 1997). Risks in relation to the case study pupils, for example, reflected single parenting, Looked After status, limitation of educational attainment and free school meals.

Summary of identified pupils

The five pupils identified were:

i) Pupil A who transferred to the secondary sector as a Refugee and Asylum seeking child and as a Looked After child, voluntarily accommodated. Social care and health were involved with the pupil. The pupil was identified as particularly
vulnerable due to trauma experience stemming from the violence witnessed in the
home county, the lack of knowledge about parents and siblings left behind and the
isolation of coming to England with only his brother.
ii) Pupil B transferred to the secondary sector with a statement of special
educational needs and as a Looked After child. Agencies primarily involved
included social care, behaviour support and health. Data indicated that Pupil B
had behavioural, emotional and social difficulties. The pupil had significant
literacy and learning difficulties as evidenced through psychological testing and
school reading tests.
iii) Pupil C was identified at transition as a very vulnerable pupil. Reports
indicated current clinical psychology involvement. The pupil had a diagnosis for
Autistic Spectrum Disorder and severe learning difficulties. School records
indicated poor literacy skills and pastoral evidence showed peer relationships
were hard to form and sustain.
iv) Pupil D had a special educational needs statement for Attention Deficit
Hyperactivity Disorder and emotional and behavioural difficulties. Services
involved with the pupil and family included: social care, speech and language,
educational psychology, behaviour support and clinical psychology. The pupil
was reported to have difficulty in accessing the curriculum and in establishing
positive peer relationships.
v) Data about Pupil E indicated the pupil had significant emotional, behavioural
and social difficulties, as well as severe and persistent learning difficulties with
regard to literacy. It was reported that the pupil struggled to access the curriculum
socially, emotionally and academically. Documentation indicated that the pupil
demonstrated aggressive tendencies.

The information from the questionnaires was then collated to build a clear picture
of perceptions, understanding and interventions. This information was then
added to that collected data from school records including, where relevant,
statement reviews, LAC reviews, data held within pupil files pertaining to exclusions, attendance and behaviour, specific case notes and files about interventions used with the child. The accumulated information thus provided an in depth ‘case study’ of the specific child.

Field trial

During the course of the research, an opportunity presented itself to explore the use of a risk and resilience framework to identify needs and establish strategies and provision with reference to a specific pupil highlighted at risk of poor educational outcomes. The pupil was not part of the group initially identified but it was the first real opportunity to utilise the framework that I had during the course of the research undertaken.

Context

School reported that there had been previous disagreement between professionals across the key services as to how the needs of a particular child were to be met. It was reported that X had a poor attendance history to school and appeared to be very dependent upon his mother. Documentation showed that X had a diagnosis for social and communication difficulties and would only engage with one or two members of staff. Reports indicated that divergent professional opinion between education and health surrounding X resulted in a request for statutory assessment being denied. This led to the Local Authority requesting a multi-agency meeting in order to unify the professionals in their understanding of the pupil. This provided an opportunity for me, as organizer of the meeting, to use a risk and resilience framework to identify X’s needs and establish strategies and provision across key service providers involved.
Methodology

I contacted the professionals involved with X and explained the context of my research and requested if we could perhaps consider the child in terms of risk factors to poor educational outcomes and commensurate protective factors. In essence, I aimed to utilise the risk and resilience framework in order to work more collaboratively with the professionals involved and thus hopefully improve that pupil’s educational outcomes.

Those in attendance at the multi-agency review involved me, as the SENCO, a designated teaching assistant, (school nurse - report only) the student support officer, the educational psychologist, the clinical psychologist, the psychiatrist, the mother and the parent partnership representative.

Prior to the meeting, all professionals were asked to consider a) the factors in this child’s life that placed him at risk of poor educational outcomes; b) what was enabling him to do well; c) what were the common concerns and priorities that professionals and parent had; and d) what our shared strategy would be. Each agency represented was asked to feed back their response at the meeting. Thus, at the multi-agency meeting, the aspects of risk and protective factors were brought to the table for discussion. A teaching assistant made notes of the factors discussed.

Although, only one field trial was undertaken using this framework, the data emerging may still be considered of relevance as it presented an actual example of risk and resilience framework use within a school multi-agency setting. The field trial was undertaken to see if there were possibilities for the framework being used within a school setting with a variety of professionals present. Further, if it could be used to support professionals to come to a shared understanding of the
child and thus ensure coordinated and effective interventions through an agreed shared strategy.

The approach to data analysis, ethical considerations, trustworthiness and limitations to the methodology are now explored in this next section.

**Approach to Data Analysis**

Qualitative data requires thorough and systematic analysis:

Data analysis is the process of bringing order, structure, and meaning to the mass of collected data. It is a messy, ambiguous, time-consuming, creative, fascinating process. It does not proceed in a linear fashion: it is not neat. Qualitative data analysis is a search for general statements about relationships among categories of data; it builds grounded theory (Marshall and Rossman, 1995, p.111).

Robson refers to different types of qualitative approaches to data analysis – that of Tesch (1990), which relates to language characteristics, discovery of regularities, comprehension of text meaning and reflection, as well as that of Crabtree and Millar (1992) which relates to data analysis methods – ‘quasi statistical methods, template approaches, editing approaches and immersion approaches (2002, p.457).

The amount of data generated within qualitative research is often large due to interviews, field notes, conversations and discussions, etc, and thus computer software is often advocated for use in analysing data. The data collected through interviewing 16 professionals and 29 questionnaires proved to be time consuming, though a structure for this process had been considered prior to implementation. Interviews were word processed immediately and analysed; the use of a specialist software package (e.g. NVivo) for data analysis was considered but rejected primarily because of the time it would have taken to achieve proficiency. For the purpose of this research, manual recording of data generated was thus utilised.
With the data collected, I had to; make sense of the data collected through analysis; identify significant patterns; interpret the data logically within the boundaries of validity, reliability and triangulation; and construct a framework for communicating the essence of what the data reveal. The subsequent analysis of data stemming from the questionnaires and interviews relates clearly to the “classic set of analytical moves” (Miles and Huberman, 1994, p.9). The analytical methods I used involved content analysis in search of emerging themes, similarities and differences. I highlighted words and phrases and categorised the data according to the individual and professional cohort, looking for similarities, differences and then drawing conclusions.

**Coding**

Qualitative research lends itself well to coding techniques in identifying particular responses, as well as supporting the organisation, quantifying and analysing of data. Data generated from the interviews and questionnaires had to be appropriately recorded, analysed and interpreted if it was to have meaning and relevance. Coding was indeed helpful in this context and I used it regularly within this research:

codes are tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study. Codes are usually attached to ‘chunks’ of varying size – words, phrases, sentences or whole paragraphs, connected or unconnected to a specific setting (Miles and Huberman, 1994, p.56 cited in Bell, 2005, p.214).

Coding certainly made it easier to search the data, to make comparisons and to identify any patterns that required further investigation. Codes in this research were based on a variety of themes such as poverty, familial relationships, technical jargon, particular conceptual references, phrases and keywords found in the emerging interview and questionnaire data. I was looking for the language participants used; particular concepts they held and any assumptions made.
Coding the texts acquired helped me to cluster respective information, thereby draw conclusions and thus reach an understanding:

Raw data can be very interesting to look at, yet they do not help the reader to understand the social world under scrutiny, and the way the participants view it, unless such data have been systematically analysed to illuminate an existent situation. Coding or categorizing the data has an important role in analysis. It involves subdividing the data as well as assigning category. Codes or categories are tags or labels for allocating units of meaning to the descriptive or inferential information compiled during a study. Codes usually are attached to chunks of varying-sized words, phrases, sentences or whole paragraphs, connected or unconnected to a specific setting (Basit, 2003, p. 143).

Throughout the data analysis, I recognised the importance to remain open minded about what could potentially be coded and in order to notice significant patterns in the data.

**Document analysis**

Content analysis was undertaken in respect of the documents used for the pupil case studies. Content analysis can be understood as technique used in research for ‘making replicable and valid inferences from data to their context’ (Krippendorff, 1980, p.21 cited in Robson, 2002, p.350). The records used within this aspect of research may be viewed as a supplementary resource and were of direct value in ascertaining a holistic view of the level of perceived need within the cohort for the study and acted as an indicator for potential poor educational pupil outcomes. The documentation which provided information pertaining to the five case study pupils, aspects regarding authenticity, credibility, representativeness and meaning had to be considered: “Their validity is something that needs to be established rather than being taken for granted” (Denscombe, 2007, p.232).

**Interview analysis**

Each interview was transcribed and data systematically analysed manually using the above coding techniques. In analysing interview data, the researcher is
inevitably utilising interpretive construction in relation to what the interviewee is purporting. That transcription can also lead to subjective construction and thus the validity of interview data invites inevitable criticism especially amongst the ‘canons of scientific enquiry’ (Robson, 2002, p.168). Thus, the role of the critical friend in looking at my conclusions drawn was important for validity and to ensure that I was rigorous in the scrutiny of the emerging data. It was imperative that conclusions drawn were evidenced well.

The data from the interviews was organised and tabulated according to questions asked, individually and by profession in summary form. Each interview question response was put under the relevant question heading according to service representation and recorded in table format (Appendix 6). The collective responses depending on profession were then presented as a summary (Appendix 7). Data collected was compared and contrasted, similarities and differences recorded and presented in a narrative and /or tabular form. Table 9 and 10 below are examples of the methodology used. Table 9 shows the responses from professionals interviewed relating to indicators for risk of poor outcomes. Common understandings are highlighted prior to a conclusion drawn.

Table 9  Children at risk of poor educational outcomes

<table>
<thead>
<tr>
<th>Education</th>
<th>Health</th>
<th>Social Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor transition: Primary to Secondary sector, Influence of adolescence Family difficulties Mental health of the parent. Children who lacked emotional and social competency A significant unrecognized learning need. Child academically underperforming Child with poor attendance Those who lacked parental care at an early age.</td>
<td>Those experiencing child protection issues and difficult home situations. Indicators included drug, alcohol and substance abuse, domestic violence within the home, lack of parental responsibility, impoverished lifestyle, physical abuse of others, mental health issues including self harm. Emotional and physical development Medical appointment history in term of non attendance</td>
<td>Poor academic performance, attendance and behaviour Those at risk of significant harm as under the Children’s Act of 1989 including too those at risk of anti social behaviour Actual impact of Looked After status Pupils difficulty accessing education for social and emotional reasons Absent parents and parents without the skills to look after their children, Families with social / economic</td>
</tr>
</tbody>
</table>
Family break up
Low self esteem and
behavioural issues.

Poverty of care within the
family.
Lack of aspiration
emotional difficulties, due to
experience of trauma

In Table 10 coding words or understandings for example, that at least two participants used, were highlighted and structured in a table form to make comparisons easier to visualise. Although this may be perceived as a crude way of undertaking this analysis, the method was effective, as it was easy to cross reference and gave me a database upon which answers to the research questions could be attempted.

Table 10  Example of coding systems used with the data collected

<table>
<thead>
<tr>
<th>Professional Cohort</th>
<th>Understanding of social risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>Different culture and values, environment and language. Problems with self confidence, low self esteem and making new friends. Easily led into unacceptable behaviour. Internal emotional suffering. Difficulties forming positive relationships, managing emotions positively, managing conflict, lonely. Lack of understanding of the meaning of friendships; easily influenced by peers. Immaturity leading to early pregnancy; taken advantage of by others; emotionally very young. Inability to comprehend social situations. Behavioural and emotional difficulties; Inherent anger leading to non acceptance by others. Alienation from peers, lack of understanding by others. Suicidal thoughts; Bizarre behaviour and body language. An easy target; lack of non verbal and verbal forms of communication; has no boundaries; poor emotional management skills; influenced by others to engage in the wrong kind of activities leading to trouble with the police, inherent anger causing problems amongst the community. Outcast by behaviour exhibited. Anti social behaviour leading to crime and trouble with the police. Risk of permanent exclusion from school. Aggression and anti social behaviour in and around the communities. Irreverence. Negative presence within the community. Family breakdown, peer pressure and social issues in and around the local area.</td>
</tr>
<tr>
<td>Health</td>
<td>Experiences reinforces differentness, lack of peers empathy or understanding. Unable to 'process' past events; “wishing to forget syndrome.” Uncertainty of status. Emotional issues relating to being an unaccompanied youngster from a war torn country. Wants to be same as peers. Unable to function in social situations; No social and independent skills – she has significant needs that require specialist intervention. Marked difference of maturation, unable to make informed judgments. Over sensitivity to other’s misery and problems. Displacement about her own self and reflection on her own life. Insecure attachments were found to be part of the problems. Struggles with social integration. At risk of isolation – little empathy with other, few friendships, little social understanding. Little support available within the community. Mild autism. Social clues are misinterpreted by the pupil. Social responsiveness misplaced creating difficult situations. Needs to be managed appropriately; condition – has to have clear boundaries enforced consistently. Needs to be understood. Risk of anti social behaviour and gang activity. Needs activities to keep occupied - far more likely to be in trouble with the police and young offenders institute. Support available within the community as such pupils have such a negative impact on the community. The pupil represents as a very angry individual, personality hampered by adverse and...</td>
</tr>
</tbody>
</table>
Questionnaire analysis

Similar data analysis techniques were used with regard to the questionnaires (Appendix 8). The following steps were taken:

i) Upon receipt of each questionnaire, responses were transcribed via word processing under each question – compiling professional responses to each question per child.

ii) An analysis of all recorded responses was placed in a table form alongside an analytical commentary, focusing on areas of commonality and differences. Data was then collated and analysed according to professional discipline - education, health and social care. Thus, data were organized according to pupil and according to professional group – commonalities and similarities recorded.

iii) Data was presented in a number of formats – narrative, coded tables and matrix and finally presented as individual pupil case study and collective summary analyses (Appendix 9 and 10).

Data from the questionnaires was then compared directly to the senior practitioner responses. The data from interviews and questionnaires was also compared to the information gathered through the review of literature to establish congruence.

Case study analysis

Each child case study had the following components; i) a summary profile of individual child; ii) collated information from professionals undertaking the questionnaire; and iii) a narrative summary of the presenting data; for example, similarities and differences of professional responses. Comparisons were then
made on an individual case and across cases as I carefully sifted through the data looking for patterns and differences with regard to conceptualisation.

The information pertaining to the case study pupils was then compared to the senior practitioner responses and to the information gathered through the review of literature to establish congruence with regard to risk and protective factors identified and resilience. The findings emerging from the data are reported in the next chapter.

Thus the data collected from a variety of sources was examined, recorded and categorised into emerging themes (Yin, 1994). I ensured that data was analysed from an individual perspective and from a collective perspective, looking for areas of difference and commonality to draw comparisons. The data was ordered in a variety of ways so as to have a full understanding of what emerged. I looked for patterns and sought explanations. The overarching strategy tended to be based on the analytical techniques informed through, for example, research undertaken by Miles and Huberman (1984) such as putting information collected in different forms, using matrix of categories and putting the evidence within such categories. I used all the relevant data and drew on the “knowledge in the area of the case study, but in an unbiased and objective manner” Rowley (2002, p. 24).

**Ethical issues**

This section examines the ethical issues raised by study and procedures used to address them. At all times, the research was undertaken within the guidelines, boundaries and codes set by British Educational Research Association (BERA).

Throughout the research design stage ethical considerations played an important role. The interviewees were known to me in a professional context only and their
relationship of an equitable nature, as opposed to any direct line management linkage. Certainly, knowledge of the interviewees made conducting the interviews easier in terms of contacting potential interviewees and knowledge of who would be appropriate to interview in terms of their specific role and involvement with the identified cohort of pupils.

The ethical issues were also considered in relation to the combined role of line manager and researcher. All the professionals and practitioners working with the identified pupils were known to me professionally, and some I directly line managed. When considering asking colleagues to fill in the questionnaires, several issues emerged in relation to their purpose for doing so: For instance, out of professional courtesy, respect or fear of reprisal if declined; the perceived pressure colleagues would feel if they did not carry out the questionnaire to the standard they thought it had to be undertaken in; the anxiety of completing the questionnaire if not understood in entirety and so on. Thus, it had to be made explicit to all potential participants the aims and nature of the research, their involvement; who will have access to data; how data will be stored; possible consequences of the research; their right to see/amend transcripts, comment on provisional data analyses; how results are likely to be disseminated; the extent to which confidentiality and anonymity will be protected; participants’ right to withdraw from study; and respect for participants’ right to privacy etc. It was made clear to all potential participants that involvement was purely voluntary. In relation to ethical guidance;

Researchers must take the steps necessary to ensure that all participants in the research understand the process in which they are to be engaged, including why their participation is necessary, how it will be used and how and to whom it will be reported. Researchers engaged in action research must consider the extent to which their own reflective research impinges on others, for example in the case of the dual role of teacher and researcher and the impact on students and colleagues. Dual roles
may also introduce explicit tensions in areas such as confidentiality and must be addressed accordingly (BERA, 2004, p.5).

Thus, I had to ensure that for all participants informed consent without coercion was crucial and made explicit the purpose and procedure, the potential research benefits, the voluntary nature, the rights to discontinue at any time and ultimately, all who were asked did comply willingly. However, three respondents reported directly and separately, to me that they found the questionnaire hard to complete as they were not sure what was expected from them and expressed worry that they hadn’t responded correctly. They were given absolute assurance that their contribution would be important and valued, and that their ‘voice’ was important. They, thereafter, returned their questionnaires. However, I was reminded of Anderson’s (1990) observation:

There are subtle forces between researcher and participant which generally makes it difficult for the participant to stop unless there is good reason (p.23).

The relationship between me as a researcher and direct line manager of participant is complex. Ethical boundaries of coercing and cajoling were considered prior to undertaking the interviews and questionnaires and it was made clear that such an undertaking was purely voluntary. I was at all times open about the purpose of the research and ensured there was informed consent from those involved in the research process. I was aware that participants, particular practitioners, may have felt under pressure to undertake the questionnaire, but I could only give reassurances that their participation was in a voluntary capacity.

I also had to be aware of being an insider and that participants may give me information that was perhaps more limited than if I had been an external
researcher. Certainly, some of the participants were wary of their responses and wanted certainty from me that it was confidential. Conversely, in, one practitioner requested a meeting about the questionnaire and thereafter offloaded much of her own personal angst that she experienced with one of the pupils and was highly critical of the service they represented. The practitioner stated that she did not back one of the decisions taken by the manager and was devastated that she had not personally given enough time a child due to constraints placed on her.

Further, as all employees of a city council, interviewees were possibly quite guarded with their responses for fear of retribution. As a researcher, all I could do was give reassurance and ensure anonymity. At all times, pupil and professional identity were protected and made anonymous, and the interests of participants protected. In terms of data collection from pupil records, the documents used were in my domain and were not used outside their usual parameters.

With regard to health, the school nurse was particularly sensitive to aspects of confidentiality. However, no specific references were made to individual health profiles or medical records. When discussing case study pupils, the nurse did not make specific reference to the individual child and always stated generalised opinions relating to children with similar profiles. This was the only way in which the nurse would participate as she was bound by her own rules and protocols relating to patient confidentiality.

There were some unexpected outcomes from the interviews and questionnaires undertaken and included:

- how low in confidence some of the teachers and teaching assistants were and the reassurances required if they were to complete the questionnaires;
how form teachers formulated their respective knowledge about case study pupils, often in isolation of actual data available and not necessarily in conjunction with the views of all professionals involved;

- some interviewees took the opportunity to off load their despair with the system that they operated in terms of lack of funding and inability to really impact on many vulnerable lives. One of the interviewees specifically made reference to letting their ‘charge’ down and used part of the time with me as a way to explain actions that they had undertaken that they were not happy with.

From an ethical perspective, such outcomes were not shared with anyone else and were mere observations on my part as the researcher.

One important ethical consideration was the use of a risk and resilience framework within a multi-agency meeting. I felt that as a group of professionals, using such a framework could bring the previously disparate professionals together. I had a good relationship with the parent and I hoped that progress could be made. As an inclusion Deputy / SENCO, I felt the framework could serve as a way forward as no consensus had previously been reached. I informed the participants, prior to the meeting, as to what I intended to do and there were no objections.

**Trustworthiness**

Practitioners who are involved in research within their own institution or organization do indeed have ‘privileged insight’ (Denscombe, 2007, p.129). However, with such ‘privilege’ comes the problems of ‘constraint of web of meanings’ (ibid p.129) and thus lack of new insight that an external researcher may acquire.
In retrospect, I obtained a great deal of information from the working links previously established. Certainly, my position aided the collection of data. Throughout the research process, I was careful to abide by the implementation of a process that ensured I was at all times detached and impartial.

Trustworthiness of research is herein considered due to the considerable debate about the applicability of concepts such as reliability and validity, and the possibility and appropriateness of objectivity, when using flexible qualitative research (Robson, 2002, p.109). Bridges (2003) refers to the importance of being aware of the philosophical assumptions one makes and being self-conscious of their presence. He suggests that where values, beliefs and assumptions remain hidden and unexamined, validity is compromised.

The methodology utilised within the research had inherent validity and reliability issues: With regard to the latter, objectivity is hard to attain:

    the data collected are...unique owing to the specific context and the specific individuals involved. This has an adverse effect on reliability (Denscombe, 2007, p.203).

Furthermore, my own identity, background, identity and belief may have inadvertently impact on data creation and analysis. The utilisation of interviews, while having several advantages such as acquisition of depth of information and insights into given situations, nonetheless incur issues concerning reliability:

    The data from interviews are based on what people say rather than what they do. The two may not tally. What people say they do, what they say they prefer and what they think cannot automatically be assumed to reflect the truth (Denscombe, 2007, p. 204).
Validity of qualitative research is hard to prove as the research undertaken cannot necessarily be replicated due to its specific nature, social setting and specific nature of the school and children involved. There is no guarantee that the data accumulated would be identical or the interpretation of that respective data. Qualitative data cannot be verified in the way quantitative data can be. Nonetheless, it is important to establish that the research is credible and trustworthy.

To ensure reliability in qualitative research, examination of trustworthiness is crucial and utilisation of triangulation of data may be considered good practice in ensuring such trustworthiness (Golafshani, 2003, p.601).

With regard to this thesis, I was fully aware of the difficulties and impact that theoretical sensitivities can have on data interpretation and thus made every effort to ensure its trustworthiness: Data analysis has been undertaken in a systematic and consistent manner, with rigour and thoroughness; ‘rigour’ applied to data collection, analysis and reporting.

As an insider, while being in a very privileged role, I was also crucially aware that I had to be a researcher, not a teacher, and this was, initially, difficult to achieve. I had to ensure that the evidence arising was seen through the lens of a researcher and not through those of a teacher. The importance of supervision clearly played an important role here, as did the critical friend. Both provided the facilitation of a constant challenge of perception and interpretation, as well as the exchange of ideas and opinions.

I also had to ensure that my own conceptualisations did not influence interpretation of data and I had to be as objective as possible. Throughout the research, in addition to regular supervision, I had a critical friend who would
regularly discuss the data collected and talk through the research, interpretations and conclusions come to. Not every transcript was read, but at each stage of the research, my methodology was questioned, interview questions were discussed, the questionnaire read and some of the conclusions debated.

Throughout the interview process, I made every effort to distinguish self as a researcher consciously divorcing self as a professional bound by own views and to remind oneself the rigour needed to compensate for advantages of being an external researcher. When interviewing, I had to ensure and assert my professional reputation as a researcher and not as a professional colleague. Similarly, when analysing data accrued, I constantly questioned my own preconceived ideas and their relation to interpreting data in order to prevent bias. Knowing the data pertaining to pupils collectively and individually, although an advantage as a professional, as a researcher, it had to be looked at totally objectively, and the critical friend deployed was important to ensure that objective interpretation. Constantly reminding myself of being a researcher not a teacher in approach to data understanding was crucial.

The method of data collection for the research undertaken involved interviews, questionnaires and documentary sources. Throughout the process, I have utilized triangulation, used reputable procedures and have been as objective as possible. Every effort has been made to ensure data has been recorded accurately and effectively, that explanation derived from analysis is verifiable and that the data collected was relevant to the purpose of the research undertaken and duly plausible. The interviews were all carried out in the same style, manner and by the same person; interview summaries / transcripts checked by the respective informant; the interview and questionnaire tested and remodeled for suitability and relevance; informant triangulation to provide a fuller picture utilized. As Denscombe states:
the opportunity to corroborate findings and the chance to see things from a different perspective can enhance the validity of the data. (2007, p.138)

The research seeks to illuminate the understanding of the different conceptualisation of children that representatives from across the key children’s services have and how these inform interventions. Participants chosen for interview and questionnaire were all key professionals working within the case study school in a variety of capacities. All were considered the most appropriate professionals with respect to the research undertaken and thus valuable in what they could offer. I did not discriminate against any possible participant or consciously refuse participation of any other potential practitioners.

Data collected was thus typical of qualitative research and fully justifiable. I critically examined my own role, potential bias and influence throughout the research process and data analysis was rigorous, auditable and entirely sufficient to support findings.

**Limitations of methods employed**

There were several inherent limitations within this research. The main limitations being the very validity of case study research, bias of interviews and difficulties associated with the dual roles of researcher and practitioner. While the role of researcher and practitioner had both advantages and disadvantages, this relationship was further complicated by the line management role, senior role within the school and main point of contact for all undertaking questionnaire. The association of undertaking a PhD generated a certain conceptualisation especially amongst teaching assistants who changed their perception towards me and were less at ease than previously was the case. There was a certain discomfort and
stereotyping amongst some staff with regard to me undertaking such a course – you somehow become seen in a different light.

There was no extended opportunity, due to time constraints, to explore the views and perceptions of pupil and parent/carers alongside those of professionals involved. Additional interviews and questionnaires with both professionals and practitioners would have also provided greater data generation. The advantage of following up interesting lines of response to interview questions and further dialogue into conceptualisations was not achieved as little additional time was available to undertake such follow up.

I had some reservations as to some of the conceptual understanding of answers given by those undertaking questionnaires. Some of the questionnaire respondents had difficulty with one or two of the questions and I was unable to understand their answers. There was too, possible bias with ensuing discussion between the teaching assistant respondents, i.e. of what one should put down in the questionnaire when an individual respondent had not understood the question. One respondent did not appear to understand the questionnaires and asked for help from another colleague, who, in effect, gave her the answer from their own perspective as opposed to the person actually given the questionnaire. The evidence collected from practitioners was not always consistent. For example, the Form Tutor and Head of Year were not included in Case Study D and E. One of the reasons was that they felt that they did not know the child well enough despite their respective roles.

There was a lack of opportunity to utilize alternative methods. On reflection, I would have extended the number of case study pupils. A practitioner undertaking questionnaires relating to more than one child proved problematic in relation to specific data generation. For example, one teaching assistant worked with three of
the pupils involved and this perhaps limited the variance of responses. Furthermore, the School Nurse was involved with all of the children and thus answers tended to be rather more generic than individualized or specific. Some pupils had the same practitioners and thus some of the questions responses were repetitive. In retrospect, I should have advised respondents to make one response to generic questions and which may have thus allowed them to have a greater focus on specific pupil related questions. Further, it may have been beneficial to have standardised the number of questionnaires per child – say five respondents to make it more equitable. Further, I would have really wanted a better representation of practitioners involved with the case study children. While it had been relatively easy for me to get a good cross-section of professionals, social care practitioners proved harder to engage due to time constraints on their part. This was particularly frustrating.

One significant limitation lay in the fact that only one example of a field trial using the risk and resilience framework was undertaken. Though the specific case was illuminating, there was neither the opportunity to follow up the example nor to repeat the process with other children. This was because I changed jobs midway through the research process, though after all fieldwork data had been collected.

While recognising the above, the data collected from the methods used nonetheless did give rise to a wealth of information. Several emerging themes may now be considered in the next chapter on findings.
Chapter 4: Presentation of Findings and Discussion

Overview
This chapter presents and discusses the findings from the various strands of data collected from the fieldwork undertaken. It seeks to collate the findings stemming from the qualitative research as outlined in Chapter 3: Methodology, in order to reach an understanding of the main research question:

To what extent do professionals working with secondary school-age children in an urban context share common understandings of the risks for poor educational outcomes to which those children are subject?

The chapter is divided into different stages to report on the different types of data collection. Stage 1 focuses on the data gathered from the responses generated by the interviewees and is followed by; Stage 2 from the school held documentation and questionnaires, and Stage 3 from the field study undertaken. Stage 4 focuses briefly on research findings in relation to the empirical review of literature. The main themes arising from the data are reported and discussed at the end each stage of analysis.

Presented from the findings are aspects of cultural and organisational difficulties relating to multi-agency working within an educational setting. The concepts of ‘risk,’ and ‘resilience,’ and from the use of a risk and resilience framework as a possible way forward for professionals from different agencies across the key children’s services are also discussed. The chapter seeks to establish if professionals and practitioners from the case study school can build a unified understanding of an individual child and thus implement a coordinated and coherent intervention. The chapter finishes with a brief overall summary of conclusions drawn.
Stage 1: Interviewee responses

An overview

This section presents and discusses the findings from data collected through the interviews undertaken with 16 strategic lead professionals across education, health and social care, working within, or having specific links to, the case study school. In this section, I will explore the themes emerging from the interviews of these professionals from across the key children’s services.

The aim is to explore professionals’ understandings of risks for poor educational outcomes, their congruence with understandings of risk in the research literature, and how interventions are shaped in relation to such understanding. The themes emerging from the analysis of professional interviews include; a) the different professional conceptualisations as determined through discourse; b) the lack of a common language; and c) critical responses towards other service providers.

Lead professionals from education, health and social care who worked, directly or indirectly, with the case study school were asked a series of questions pertaining to the school’s immediate surrounding community, within a specified postcode. The presentation of findings relates to the order of questions undertaken during the interview process. For each question a thematic summary of the professional responses is given. These collective responses refer to where at least two professionals within the same professional service give comparable information. Where individual responses are used, they are highlighted as such. Quotes from professionals are reconstructed only for grammatical purpose, for example, verbs and conjunctions, etc. For each question there is an extended explanation pertaining to aspects of commonality and difference across the key children’s services and a summary.
Responses to interview questions

a) Children at risk of poor outcomes and poor educational outcomes

Professionals were asked as to their understanding of children being at risk of poor outcomes and poor educational outcomes. Although professionals were asked these two questions separately, they elicited very similar responses, and thus they are reported together.

Responses across the children’s service providers tended to fall into broad overarching themes: a) familial factors; b) educational factors; c) social and emotional factors; and d) community / societal factors. Each theme is looked at and the corresponding professional understanding is given. The similarities and differences in their understanding of children at risk of poor outcomes and poor educational are explored in more detail below.

Professional responses from Education

Familial factors: The majority of professional responses focussed on the structure of the family and parenting capacity as prime factors leading to poor outcomes due, for example, to “single parents, young mothers, estranged partners, mothers with different partners and different children” (Behaviour Support Manager). There were references to the impact of parent stress including the mental health of the parent and the relationship between the adults and children within the family setting. Several professionals recognised that “family domestic abuse is a big problem” and that families “battle with lots of conflict” (Educational Psychologist). One professional suggested that family difficulties in terms of lack of nurture and inadequacy of parenting contributed “to the attractiveness of gangs and crime amongst children” (Headteacher 1).
There was a general consensus that some parents often did not value education because of their own circumstances or experiences with the education system. Further that the lack of care or interest in their child served further to negate its value and thus the child did not see education as being worthwhile:

Parents who have not succeeded themselves and therefore education is not supported.... if the support is not there the children have no chance.... There has to be joined up support between home and school if the child is to succeed (Behaviour Support Worker).

One professional stated that parents were often not sure how to educate their child and, in some instances, believed it was the school’s job to do that and not the parents:

Parents are not sure what to do with a bright child and consequently there is little home support for children with for example, homework - it is viewed as the school’s job to educate, not a parent’s role (Education Outreach 2).

**Educational factors:** Educational professionals tended to see children in terms of how they performed in school in relation to their cognitive ability and how they engaged with the curriculum. The lack of basic skills acquisition, due to “... significant unrecognised learning needs,” (Educational Psychologist) and poor curriculum content at an early age, were also considered precursors for poor educational outcomes:

The Education Department does not pick up on the difficulties some of the children face. Education is not tailored to meet their needs at a crucial age, the foundation stage is important but so are the transition years Year 5 – 7 (Behaviour Support Specialist).

Pupils who presented as being generally disengaged from the curriculum, due to learning ability, emotional difficulties and /or general disaffection, were also highlighted by some of the professionals:
Their ability to access school structures has crucial influence on pupil outcome. If they are unable to access what is on offer then they won’t do well (Headteacher 2).

There was a general consensus that outcomes were poor where there was poor engagement with school, irregular attendance and failure in the key basic skills. Three professionals referred to school itself as often contributing to poor educational outcomes due to not a) addressing learning needs of the child and b) providing a curriculum that was inaccessible which impacted upon learning and behaviour:

...where the individual child is not taught; material not broken down in the way they can understand, not differentiated, the whole class is taught not the individual. This leads to frustration, the child acts out: e.g. walk out of class – it’s their way of coping; to find a way out. They are not behaviour issues per se – more a reaction to not being taught. There is no one in school to talk to... [they need] someone in school to talk to about issues in schools and strategies to deal with them (Headteacher 2).

**Social and emotional factors:** There was a professional consensus regarding children who were particularly vulnerable due to social and emotional issues which impacted on the child’s ability to access education. Aspects of low self esteem and confidence were considered by several professionals as important factors that influenced children’s outcomes, as were those:

...who have not achieved emotional and social competency ... finding impulse control and relationships very difficult (Educational Psychologist).

Some professionals commented that a child’s ability to access the curriculum was related to aptitude and or behaviour. However, no real reason was given for underlying behavioural difficulties other than lack of emotional competence. Poor educational outcomes were due to children being “unable to engage with the
curriculum due to behavioural difficulties” (Headteacher 2). One headteacher stated that emotional competencies stemming from family difficulties rendered the child with an “inability to emotionally to cope with everyday things leading to poor outcomes” (Headteacher 1). The Behaviour Support Specialist outlined a particular case who was told by the relative; “When x was born he had 666 tattooed on his head. Little devil lived up to it.’ The latter asks; “What chance has this child who is told constantly he is a ‘little bastard?’”

There was a consensus amongst the professionals regarding of the importance of relationships as a key factor for poor outcomes - be it with adults or peers, particularly amongst those “emotionally fragile children” (Educational Psychologist). It was a generally held view that those children with no positive adult or peer relationships within school, with no one to talk to, rendered children at risk:

Children who are experiencing poverty, relationship conflict and general lack of care by adults....[Children] feeling failure and defeat in school, some don’t go to school as it is not seen as valuable or worthwhile. School is often regarded as a horrible experience (Educational Psychologist).

One professional stated that poor emotional and social competence often exacerbated the negative influence of peers and linked poor social and emotional competencies with potential gang affiliation:

The child, being unable to make right choice for fear of being isolated or bullied, will follow the crowd and follow the gang (Education Outreach 1).

**Community / societal factors:** Some education professionals referred to the poor economic backgrounds where the children came from and lack of employment opportunities that existed within the community. The lack of amenities due to
economic disadvantage, in particular, the lack of activities for children and childcare facilities was considered a difficulty for families within the locality. The association of crime and poverty within the area was clearly recognised with children “living in huge crime related areas with poor social peer groups” (Education Outreach 2).

Most professionals recognised the socioeconomic difficulties within the community and the consequent impact on education. One Headteacher referred to the “lack of good education within the community” (Headteacher 1). This was qualified by reference to Ofsted criteria which indicated that all the local schools were not considered to be high achieving schools due to sequentially poor SATs and GCSE results.

The preponderance of negative familial history in terms of an ingrained lack of aspiration and ambition, and poverty, were also considered to be associated with poor outcomes:

Education and school has failed their parents, an ongoing circle; some break out but the level of deprivation mean that opportunities to do so are not so good (Behaviour Specialist).

Some professionals considered that social deprivation amongst low income families often diminished the value of education with the parent emphasising the importance of getting a job as opposed to going into further education; in particular, there was familial low expectations especially where education and school had failed their parents and their parents before them:

an underlying expectation of failure and the lack of drive to succeed in education (Education Outreach Worker 2).
Professional responses from Health

Familial factors: Most health professionals reported that home life was significant in determining poor outcomes and referred to “broken homes – perhaps one parent or no parent just grandparent being there” (Art Psychotherapist); “chaotic home lives ...and the immense freedom with children out on the streets” (School Nurse) and the difficulties stemming from “family dynamics” (Clinical Psychologist). There was a general consensus amongst Health professionals regarding the emotional impact of familial difficulties which made the ability to learn difficult:

Harder to fit work in to their mind space as other things dominate minds – education not fostered – working outside school to make ends meet at home, baby setting - emotional difficulties preventing their learning (Art Psychotherapist).

One health professional referred to those who were victims of sexual abuse and those children who acted as young carers and the difficulty that learning presented to them. Some professional responses focussed on the longer term outcomes or impact pertaining to the family difficulties such as mental health and psychological responses to adversity relating to family break up and “lack of attention of any care givers” (Art Psychotherapist).

Two professionals highlighted that family difficulties and lack of parent nurture led to children wanting involvement with gang culture: It was seen as a response to:

finding an appropriate group to be long too substitute group / foster sense of belonging missing at home.... a pseudo adult / carer for siblings / parents/ pregnancy / fathering a child (Art Psychotherapist).
However, the gang involvement was perhaps seen within a medical perspective in that it related to the child’s “attachment issues relating to family stressors” (Clinical Psychologist): an underlying psychological difficulty relating albeit perhaps to a societal cause.

**Educational factors:** Health professionals had very limited responses with regard to specific educational factors leading to poor outcomes. Only one professional from health defined a child as being at risk of poor educational outcomes if they were unable to access the school curriculum. The exception was the School Counsellor who suggested that such children were:

> The low achievers in life; pupils performing under national curriculum levels and who have poor communication skills.

**Social and emotional factors:** Health professionals agreed with each other that children were at risk of poor educational outcomes due to, for example, emotional problems, which impacted on their ability to cope with activities of daily life and social interactions. There was a tendency, however, to view such difficulties within a framework of mental health due such as a child experiencing a particularly traumatic event. Health professionals tended to focus on the psychological impact of difficulties such as the child’s low levels of psychological resilience and poor self esteem which resulted in mental health problems, attachment issues and, often, substance abuse. The Horticulturist, for example, specified “limited internal coping mechanisms” and referred to significant emotional difficulties “impacting on their ability to cope with activities of daily life and social interactions.” Such emotional difficulties led to children having poor learning experiences as children became “disengaged and unenthusiastic” (Horticulturist).
Most professionals indicated that poor social competencies and, in one case, “disorders of impediment” (Counsellor) impacted on poor educational outcomes. Some professionals referred to those children who had suffered particular trauma, sexual and non-sexual assault. Such children often requiring evidence-based support involving psychiatry or psychology. Although mental health issues were alluded to by several professionals across the key children’s services, those stemming from the health professionals were far more specific in definition. For example, there was reference to the consequential:

- risk to self or others; issues to self / self harm, Para suicidal / suicidal thoughts; issues around violence towards others, physical abuse to others / self (Clinical Psychologist).

Two health professionals referred to the inappropriate role models on TV and media stereotypes as a contributing factor to poor educational outcomes. The Clinical Psychologist spoke of the negative influence of the media and concluded that children faced poor outcomes due to this “demonic force.” The other stated that the media promotes:

- certain characteristics of male – power to dominate and acquisition of material wealth as opposed to being a good father / husband through music and film, evidenced what they see at home where there is often no father figure at home (Art Psychotherapist).

**Community / societal factors:** The majority of health professionals referenced general poverty within the area as demonstrated by social housing and the poor lifestyles that families led. There were specific references to poverty in terms of “financial disadvantage, council estate accommodation / environment” (Art Psychotherapist).
The professionals interviewed generally spoke only of the impact of the community in terms of the lack of resources available and aspects associated with impact of poverty such as the preponderant lifestyle risks of smoking, using cannabis, drinking alcohol, aerosol abuse, criminality and attraction to gangs. One professional stated:

Lack of appropriate resources and inability to think creatively about what to do about free time... can lead to crime – not enough community groups - no sense of belonging (Art Psychotherapist).

Some of the professionals made reference to the general health risks and health trajectories that families faced within the deprived community. The Nurse spoke of children being at risk within the community area in terms of general child protection issues and indicated that the school at the centre of this study had “a long list of non attendance to [medical] appointments.”

The responses from health professionals could be seen as being framed in a medical framework, indeed, both the Clinical Psychologist and Art Psychotherapist stated that the inherent characteristics of the child determined poor outcomes. In one instance, when asked to give their understanding of a child at risk of poor educational outcomes, the following response was given;

A broader definition would be to consider risk factors. One would look at physical / emotional development – not necessarily based on child protection thresholds but on basis of training – clear issues which might pose a risk to health and physical / emotional development – one would look at developmental trajectories, attachment relationships, social stresses / family dynamics; illness, congenital / constitutional factors; we take into account risk to healthy development (Clinical Psychologist).
Overall, there tended to be a wider context in which health professional viewed the impact of family difficulties, though, as we see later in more detail, there was a degree of commonality with education and social care professionals.

**Professional responses from Social Care**

**Familial factors:** Social care professionals generally appeared to pay greater attention to the role of the parent, in particular parenting capacity rather than the actual constitution of the family. Most professionals tended to emphasise that it was the lack of parental capacity that influenced poor outcomes as opposed to how the family was constituted. There were frequent references to; “lack of good parenting” (Family Support Worker 2); “lack of parent care” (Senior Practitioner); “poverty of parenting” (Lead Social Care Manager); “lack of parenting ability” and those “unable to parent” (Family Support Worker 2). The difficulties of being a one parent family were mentioned by an individual professional but in their capacity to parent appropriately rather than focussing on the societal aspect of being a single parent.

All social care professionals cited family breakdown as one of the main risk factors for poor educational outcomes. One professional saw the breakdown as a result of “abuse within the family home, including incest” (LAC worker). In terms of neglect and child protection, social care professionals were often specific in detail, referring to sexual, physical and emotional abuse during the interview process.

All social care professionals’ responses drew particular attention to the wider implications pertaining to the family difficulties and referred to their detailed knowledge of the complexities of family life and the impact that family difficulties had on children:
... lack of mother figure, unemployed parent, large families dealing with lots of issues – socially, court cases, absent parents,...Sometimes fathers are in prison ...sometimes whole family is involved in crime, violence, prison – normal way of life – for us not acceptable (Family Support Worker 1).

There was a consensus amongst social care professionals regarding the impact that significant poverty had within the locality. As one professional stated:

Pupils have a translucent look due to lack of nourishment – they look poor, both the parent and the child (LAC).

Social care professionals appeared to see family difficulties in terms of lack of parental care and the inability to parent, often exacerbated by societal problems relation to poverty and with some answers tending to be framed within a child protection perspective.

**Educational factors:** The majority of social care professionals referred to poor attendance and curriculum engagement as being related to poor outcomes. However, responses appeared to be framed within a child protection framework. For example, poor attendance was attributed to the fact that the parent did not take responsibility in getting the child to school and thus were negating parental responsibilities: “No attendance in school means no one is monitoring them” (Senior Social Care Practitioner). Underachievement and non engagement with the school curriculum tended to be attributed to parental illiteracy and lack of parental support, academically and emotionally rather than due to cognitive ability or aptitude. Children with poor basic skills were readily identified by the majority of social care practitioners as being at risk for poor educational outcomes but the emphasis was on the impact of a child’s subsequent lack of confidence:
No confidence has a real impact on children – can’t read, no literacy skills and this can lead to exclusion due to behavioural difficulties (Family Support Worker 1).

The latter also made a criticism towards schools within the community as a whole:

Often pupils are bored, not stimulated. Teaching is a problem – not adequate delivery of the curriculum and the curriculum itself does not always accommodate the children... School is a stressful educative experience but children find a coping mechanism which is often a negative one. Pupils want to learn but cannot access education as it is (Family Support Worker 1).

Lack of progression in school was attributed by some professional to the effect of abuse where basic needs are not being met and thus:

the child cannot function adequately There is no love or care. The child can be cold, hungry, tired, lacking focus, which means that their outcomes are poor (Family Support Worker 2). One professional referred to the prevalence of underachievement amongst Looked After Children but again this was attributed to family life and in particular the “chaotic period prior to being taken into care” (LAC Worker).

There was a focus too by the majority of professionals, on the importance of relationships with difficulties explained as due to a lack of family modelling - the parent not having taught the child essential social skills. The impoverishment of aspiration and ambition amongst the parent was highlighted as an underlying cause of poor educational outcomes and attributed to the prevalence of unemployment within the community, thus rendering education as unimportant:

There is no aspiration because their parents do not have any. There is unemployment, no aspiration or ambition. Some fathers are in prison, what is the child going to be like given there is no employment...children tend to follow the same pattern (Family Support Worker 2).
Social and emotional factors: Some professionals highlighted lack of social competency and the apparent “normality of poor social situations” (Family Support Worker 1):

... children are unable to read cues when mixing in groups – loud and inappropriate, don’t know how to behave in groups and end up excluded (Senior Practitioner).

Again, the focus was placed on the parents’ inability to teach their child socially appropriate skills. However, although professionals clearly recognised poor social and emotional competencies and relationships as key factors to poor outcomes, their views were generally tied to child protection related issues. Referring to children, it was specified:

If abused in any way there will be poor outcomes especially where there is sex abuse as this will interfere with their normal development in life especially building relationships which is very hard for them. Sexual abuse will interfere with normal development in life - building relationships becomes very hard (Family Support Worker 2).

Social care professionals cited behaviour and a negative attitude towards school as important factors for poor educational outcomes but most professionals linked the emotional difficulties pupils as the underpinning factors. As with education and health, the impact of social and emotional difficulties leading to mental health issues was alluded to, but one social care professional emphasised the particular impact it had on Looked After Children:

By 14 many become so disaffected that they can’t come to school. Often they have 5-6 major moves, too many schools; residential homes are often the worst provision – end of the line – like a prison system as they often pick up more than they went in with. Homes are often in very deprived areas and children become even more at risk. They have mental health issues - self harm, self abuse – through prostitution both boys and girls. Often children
talk to themselves, make noises, bang heads against the wall, violent reactions (LAC).

The lead professional for social care was very specific in defining children at risk of poor outcomes, more so than any other professional group or individual stating:

We concentrate on those at risk of significant harm as under the Children’s Act of 1989; looking at children at section 3.1 threshold; those at a risk of significant harm; at risk of anti social behaviour; at risk of Youth Offending.

**Community / societal factors:** All social care professionals referred to the impact of being in a hugely disadvantaged community. In particular, they focussed on the familial patterns established within the locality, as well as the connection between poverty, unemployment and crime. Most professionals emphasised the economic difficulties that the families face due to unemployment. These difficulties were sometimes attributed to familial circumstances such as illiteracy and lack of qualifications, but more often due to the insular aspect of the community and generationally entrenched unemployment within the community.

One social care worker stressed the ‘evils’ of society in their explanation, in particular, class and poverty. There was also one reference to the impact of poverty with regard to children taken into care:

Residential homes are often the worst provision – end of the line – like a prison system as they often pick up more than they went in with. Homes are often in very deprived areas and children become even more at risk Homes are often targeted for the young girls. Residential homes incorporate risks. Children often fail to engage and indeed, agencies fail to engage children. There are often significant mental health problems and they never get the necessary support (LAC worker).
Aspects of commonality and difference across the professionals

Professionals across the key children’s services pointed to comparable risk factors that led to poor educational outcomes, in particular poverty, family breakdown and children’s poor social and emotional competences. Across the children’s providers interviewed, poverty appears to be a clear determinant of poor outcomes, often inextricably linked to adverse family relationships. The influence of the family and their respective value of education was considered by some professionals across the key services to have direct bearing upon educational outcomes. There was some commonality too with regard to different values held within the family in terms of having enough money to make ends meet as opposed to continuing the learning process.

Most professionals all recognised the disadvantage present within the community and the impact that poverty had for example, on community breakdown, academic achievement, lack of resources, crime and substance abuse.

While there appear to be common themes in defining children at risk of poor educational outcomes there are apparent differences due to the frameworks used by the different service providers. These differences become more evident when one drills down into the data responses and they tended to be related to professional conceptualisation rather than within a wider perspective. Education, health and social care professionals all tended to bring in specialist aspects of their involvement with children. For example, education professionals recognised the association of poverty and unemployment on education in terms of ‘poor schooling’ and lack of aspiration. Health tended to view poor outcomes as having a medical or emotional basis. Social care responses often related to societal and child protection issues.
Education and social care professionals were focused on the wider impact of unemployment and poverty and its association with crime and family breakdown. Health professionals, however, saw poverty within poor lifestyles led and its impact on the quality of healthcare provision.

There were differences too in understanding underlying causes of children being at risk of poor educational outcomes. Most educational professionals tended to focus on how children were in school and sought explanations within the child such as the child’s behavioural difficulties and specific individual needs. Education professionals tended to see poor outcomes broadly within an education context - for example, the child’s ability to access the curriculum and how social difficulties may impact on educational trajectories. Health professionals however, tended to use a pathology model to view the child’s needs, referring to particular conditions that children might have that impact on outcomes such as ‘ADHD’, ‘depression’ and ‘disorders of impediment’ (Counsellor). Health professionals referred to children as at risk of poor outcomes based on medical needs or related health issues – the ‘coping mechanism’ and ‘disorder’ aspects - a ‘pathologised’ interpretation. Social care professionals tended to focus on the role of the parent and family and society and impact on achievement within school.

The findings indicated that health and education professionals appear to have more comparable understandings and this may perhaps be due to the closer relationship between the professionals within the context of the school - the sharing of information and joint working between them linked to Healthy Schools agenda may be a reason for this.

Professionals from health and social care clearly show referencing to their own conceptual frameworks. Whereas professionals across the services spoke about mental health, health professionals used specific referencing based on strict
medical definition. This is particularly evident within some of the language used by health professionals for example, emotional and physical developmental trajectories; congenital and constitutional factors, etc. There is similar, though not as extensive, evidence within social care responses such the societal difficulties within the community and the various thresholds of child protection, with the lead Social Care Manager specifically referencing the underpinning reference of the Children’s Act of 1989. Such language and terms of referencing perhaps indicate the specific conceptual perspectives of held by their profession.

**Conclusion**

The professionals interviewed showed a comparable understanding with regard to the risk factors that led to poor educational outcomes. There was considerable overlap of identified risk factors. All had commonality with regard to crime, family influence, drugs and alcohol. Poverty was seen in a variety of ways such as overcrowding, deprivation, low income, financial disadvantage, unemployment and economic poverty.

Although there is consensus amongst the professionals regarding poor educational outcomes, and indeed with the review of literature pertaining to risk factors, the emphasis given is different due to the specific backgrounds and perspectives of the professionals involved. The responses tended to be framed within their ‘professional lens.’ There is some evidence to suggest that social care professionals see the child from a societal perspective - the difficulty the child faces is due to ‘poor social situations’, the relationship between poverty and unemployment and aspiration - the fault lies within the domain of society. Health and educational professionals tend to look within the child for explanations - ‘disengaged because of behavioural issues’ that the child has.
Despite overlap regarding risk factors for poor educational outcomes, their interpretation was often different. The societal explanation used by social care and pathology model used by health professionals indicate clear differences of in how professionals working with the same cohorts of children understood them.

b) Risks that children face within the community

Professionals were asked as to their understanding of the risks that children faced within the community, as; ultimately, they would affect poor educational outcomes. There is a clear overlap with responses given in the previous section, but there is more specific detail given below, giving one a greater insight into the risks children faced within the community.

Common themes emerged from the interviews undertaken, for example, lack of aspiration, alcohol and drug abuse. There was particular commonality between education and health professionals in relation to issues, for example, of poor housing; unemployment; domestic violence; insular lives; crime; and mental health. Professionals across the services tended to view community issues from economic, health and social perspectives.

Professional responses from Education

Educational professionals commented on the level of poverty within the community due to the lack of well paid or high quality jobs, lack of jobs and high unemployment within the area. Economic poverty, unemployment and expectation of failure were considered dominant issues within the community. Associated with this poverty were the poor levels of accommodation and overcrowding that existed within the community; they referenced the impact of substance abuse, such as ease of access to drugs and the associated aspects of
crime and gangs. The stress of living within the community was highlighted as a particular concern for children and rendering them susceptible to the:

... influence of gangs and involvement in anti social behaviour, and risk of criminal activity...young people have better things to entertain them out of school in terms of gangs and criminality (Outreach Worker 1).

One professional referred to the issue of crime and drug culture being respected within community and the kudos and high status that associated families had within the community; “violence and crime is seen as an attractive proposition” (Education Outreach Worker 2). One professional referred to the lack of community affiliation due to the high rates of mobility that existed within the community relating to people from overseas and the associated difficulties of racism and trauma that some of the refugee and asylum seeking population experienced (Headteacher 2).

Several education professionals also referred to the impact that poverty had on associated social issues - in particular mental health and the difficulties of arising out of poor parenting due to lack of nurture and the arising issues of substance abuse. This in turn leading to:

chaos within family life, attachment disorders and chaotic attachments ...contributing to the attractiveness of gangs and crime; there is an affiliation - the gang looks after you (Headteacher 1).

As reported previously, there was reference to the lack of aspiration, expectation and poor schooling within the neighbourhood; an underlying expectation...not so much drive to succeed in education...not seen as important (Education Outreach Worker 2).
Professional responses from Health

Health professionals focussed on the ill effects of poverty and wider resulting community issues. One professional stated:

There is no work ethic; it is an area of low achievement, divorce, alcohol and drugs. There is poor accommodation, no well paid or high quality jobs. Parents represent low achievement in families – perpetuated by the want to be on the dole – often families of the 3/4th generation who have a baby, state housing and on the dole. The families become that role model – state will take care of you eventually. Parents often represented low achievement and aspiration in families, perpetuated by the want to be on income support. Families become that role model perpetuating the belief and aspiration that the state will take care of you eventually (Counsellor).

Health professionals also stressed the impact of poor parenting, economic disadvantage, the high level of domestic violence experienced by children and the community issue of alcohol, drugs and crime. As one professional stressed:

The huge impact of living in a deprived inner city area – poor housing, poverty, mental health, drugs and alcohol misuse, unemployment (Clinical Psychologist).

Health professionals referred to the significant number of children who presented as very vulnerable and the substantial inequalities in health that many families faced. The risk of teenage pregnancy was highlighted by one health professional, with the need for some girls to establish “an identity outside a mutually loving relationship” (and) with boys, there was the draw of gangs and crime as a counter to “boredom experienced” (Art Psychotherapist). The latter referred too to the insularity of children’s lives within the community; “they do not go to the countryside or to the hills to see all that there is to do or see” (Art Psychotherapist). The School Nurse summarised the frequent difficulties faced by children in the community in the following way:
Children have issues with regard to behaviour, domestic violence effects; sexual health – promiscuity, lack of self worth, risk of exploitation; not coping – insecurity, tearfulness, feeling that they cannot survive as an ordinary teenager (School Nurse).

Another health professional outlined his concern for those in the community who had witnessed acts of war, suffered personal and direct trauma and thereafter asylum and the difficulties faced within their new environment:

[There] came the uncertainty of asylum application and struggle to cope with normal activity – everything enabling one to carry out daily life - all this becomes traumatic. Often families feel that once in England everything will get better but this is not the case – life becomes even more traumatic (Horticulturist).

One dissenting view came from the Art Psychotherapist who emphasised that children “struggle to finds a meaning in their lives,” adding:

Children have no spiritual dimension to their life ... there is lack of meaning, a feeling there is nothing to fuel awe about – nothing to generate awe or create awe – it leaves people in a void (Art Psychotherapist).

This rather unusual, albeit a personal view, perhaps stemmed from working with particularly traumatised and vulnerable children within the locality. However, it serves to illustrate the extent of difficulty that the professional faced.

**Professional responses from Social Care**

Several social care professionals again focussed on the general poverty of the area, especially the run down facilities and general high level of deprivation. Their focus tended to be related to associated difficulties of family life and one professional again expressed concern at the levels of child abuse within the community, including “sexual, emotional and physical abuse” (LAC).
It was, however, the impact of poverty that the majority of social care professionals emphasised regarding risks within the community. The association of economic and social factors is perhaps exemplified in the following statement:

The significant loss of heavy industry has led to abject poverty in terms of parenting capacity. Communities have broken down. There is lack of employment and a poverty of parenting – child death, such as accidental child death is high – due to fire for example ....to problems with parental supervision, drugs and alcohol which renders parents incapacitated. There are immense parenting difficulties – often their priorities are misplaced. Unemployment can lead to parents not being in supervision of children. Bereavement within this locality is a huge issue (Lead Social Care Manager).

Some professionals referred in particular to the associated problems of poverty such as drugs and street crime. One professional spoke about “racial tension and the peer pressure to conform” (LAC). Another stated:

Socially, the area is run down. There is much deprivation, it is a poor environment, and there is no aspiration. There is a vulnerability of children – nothing for them to do, their parents are often violent - this is the nature of the community (Family Support Worker 1).

**Aspects of commonality and difference**

While there is commonality amongst all professionals with regard to community risks there is also a professional conceptualisation that appears to influence the discourse undertaken. For example, the specific issue of trauma relating to refugees within the locality was commented upon, by educational professionals, only in relation to the impact it had that on the schools, such as on resources that have to be secured and academic attainment. Health professionals refer to the specific health difficulties faced by families and the substantial inequalities of health within the area, as well as the community resource requirements for those families with children who have with special educational needs and physical
difficulties (School Nurse). The difficulties that refugees have within the community are seen within a medical perspective with the focus on effects of trauma and the impact on those who, for example, have been a “witness to acts of war” (Horticulturist). Social care professionals emphasised incidence of family breakdown and child abuse associated with societal poverty. Their responses are largely within the domain of family and society - the difficulties of family life, child abuse, the impact of poverty on poor parenting and contributing to “broken communities” (Lead Social Care Manager). The family is at the centre of responses to community issues such as the social effects of one parent families; the high incidence of accidental child deaths and the issues of resulting bereavement; family breakdown and general child vulnerability.

**Conclusion**

All professionals showed insight into the difficulties that those in the community often faced, informed through work undertaken with the children and families from the case study school. There is a clear commonality of agreement amongst the professionals. The key indicators with reference to community risk factors are found in Appendix 11.

There are clear links between the different professional services. In some instances education borders onto health and social care, and health relates to social care, etc. This may, in part, be explained by the overlap of professionals working across organisational perspectives. For example, the social care family worker works within a social care remit but operates within a school. Similarly, the art psychologist has a health training background but works within an educational setting. The LAC person crosses all three domains.

Commonality may also be explained by the context in which education, health and social care professional’s work. For example, they all work with families and
children and all see the impact of drugs and alcohol on the families they work with. The professionals collectively agree that crime, drugs, poor parenting, poverty, etc, are core community issues. Certainly, perspectives appear to merge.

As all the professionals were related to education directly or indirectly, there would inevitably be some expected areas of commonality although there were different emphasises due to the role they have or the circumstances in which they operate. For example, the school nurse places great emphasis on the high incidence of domestic violence within the locality. Although the Headteachers, for example, understand domestic violence is an issue amongst the families they work with, they are not necessarily entirely aware of its full extent due to issues of confidentiality within the health service and with regard to police records - they will only have a perspective formed from those within their specific context. There is, however, a greater congruence of understanding between health and education than with social care. This may be, in part, explained by the fact that those health professionals all work within an educational setting on a regular basis, whereas social care professionals tended to work with named families within a community setting. Further, that the Government supported Healthy Schools Project provided a deeper, or at least a more consistent, partnership between health and education.

Educational professionals’ understanding of the community is perhaps determined through working with parents/carers and children and the issues that are brought into the classroom situation and on individual learning. Health and social care professionals’ understanding is perhaps determined by the impact that poverty has on the family and community as a whole, and the associated arising issues. For example, from social care came the particular issue of high incidence of child death due to ‘misplaced parenting’ priorities (Lead Social Care Manager) and thus bereavement issues. Health tended to be focussed on health inequalities
within the community, as well as non attendance to medical appointments and non compliance of medical advice.

c) Professional views of the major concerns / or risks faced by children

The aim of this interview question was to highlight the predominant issues that the professionals considered concerned the children, at the time of the interview. The responses indicated the professionals’ insight as to the child’s perspective and the impact it had on the child. The concerns fell into two broad themes - relationships and community. Again, there is considerable overlap with previous responses but more specific detail is given below. All professional groups fed back common problems of alcohol, drugs, criminality and family relationships. However, the professionals also had different perspectives on some of the issues arising.

Professional responses from Education

Education professionals tended to refer to the impact of difficulties experienced in relation to school expectations, in particular, recognising the barriers to learning; children not being able to achieve and /or not being able to meet school expectations. Professionals suggested that barriers led to pupils:

falling out of the system….as expectations are inappropriate – pressure on schools to achieve what isn’t the most normal or appropriate thing for certain children especially those with special educational or additional needs (Outreach Worker 1).

The difficulties of home life and the impact it had on the child’s education tended to characterise responses given, for example, lack of life skills and personal skills, risk gang involvement and drugs and alcohol:
Living with addiction; grieving for the parent enamoured by drugs such as crack cocaine and alcohol and the ensuing chaos within family life (Headteacher 2)

Some professionals felt that safety was a major area of concern that children had both regard to bullying and crime related activity:

“General safety is an issue especially at night. This is a pretty rough area; there are gangs, especially in certain areas (Outreach Worker 1).

Children are open to physical attack from within the community and peer groups (Outreach Worker 2).

The latter perhaps summarises the extent of the difficulties some children faced on a daily basis:

Children blaming themselves for breakdown and family breakdown this leads to big self esteem issues. Not knowing their future and the uncertainty of everything. Children’s vulnerability and putting themselves at risk because they feel no one cares e.g. expose to sexual exploitation, shoplifting, going off with strangers (Outreach Worker 2).

Professional responses from Health
The majority of health professionals tended to focus on the psychological and health aspects of relationship and community issues and its impact on children, for example, anger, high levels of anxiety and lack of self control. One professional felt that any subsequent interventions were limited and ineffective because of the impact social issues had on children – that the issues children had and chaotic lifestyles experienced negated effective psychological interventions.

I often feel that I am battling against factors outside the area, control or remit of psychological intervention (Clinical Psychologist).
The impact of issues faced was sometimes explained through a ‘medical’ interpretation with the Horticulturist, for example, focussing on “internalisation and repression of thoughts and feelings.” One professional suggested that relationship and societal difficulties led to pupils experiencing lack of self worth which rendered them at risk of exploitation (School Nurse).

**Professional responses from Social Care**

Most social care responses tended to focus on the home situation and how children related to parents and siblings. Social care professionals often emphasised the importance of the child being listened to and of feeling loved. Societal issues were also prominent, with different social care professionals referring to the direct impact poverty had on children and the home, for example, such as a child’s worry about familial debt: “The risk of losing their home due to rent arrears” (Family Support Worker 1). Home life was also emphasised in relation to children being left alone to fend for themselves and basic needs not being met.

One social care professional stated that children often play down risks that they faced:

> 90% of children minimise the risks that they are facing. They do not recognise emotional abuse e.g. the manipulation, arguing (Lead Social Care Manager).

This is partly explained by the possible stereotypical view of the social care provider – that the child will be taken away if complaints are made. However, it may be also be explained by the fact that abuse is part of their everyday life and are accepting of it.
Aspects of commonality and difference
The responses given by the professionals indicate aspects of commonality but there were some difference. For example, the term ‘worry’ is used by social care and education professionals but within health terms such as anxiety; depression, repression and mental health issues are used.

Conclusion
The responses given were usually associated with specific professional roles. With education, the focus was on not being able to cope or do well in school and with health; it was impact that factors such as family discord, stress, etc, had on personal physical and mental health. With social care came the focus child protection issues such as lack of basic provision and child abuse.
The data provided showed an insight into the lives that children had, all professionals across the key services appeared to know their community well.

d) How professionals identify children at risk of poor educational outcomes
Professionals were asked how they identified children at risk of poor educational outcomes. For purposes of clarity and comparison, responses are presented in a tabular form in Table 11 below. How professionals identified pupils at risk of poor educational outcomes are recorded below and placed into the corresponding categories that emerged through analysis of data. The categories are indicated in bold italics in the table below e.g. Data analysis
Table 11  How professionals identify children at risk of poor educational outcomes

<table>
<thead>
<tr>
<th>Education</th>
<th>Health</th>
<th>Social Care</th>
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<tbody>
<tr>
<td><strong>Data analysis</strong></td>
<td><strong>Data analysis</strong></td>
<td><strong>Data analysis</strong></td>
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<tr>
<td>Attendance</td>
<td>Child health computer system stress indicator checklist;</td>
<td>Poor / non attendance to school</td>
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<tr>
<td>Exclusions</td>
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<td>Behaviour</td>
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<td>NFER data</td>
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<td>Performance in around school</td>
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<tr>
<td>Progress with learning, Pastoral information</td>
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<tr>
<td><strong>Knowledge of parent / family</strong></td>
<td><strong>Knowledge of parent / family</strong></td>
<td><strong>Knowledge of parent / family</strong></td>
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<tr>
<td>Parental difficulties with child</td>
<td>Information about the family</td>
<td>Parental issues</td>
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<tr>
<td>Parental difficulties themselves</td>
<td>Poor parental control</td>
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<tr>
<td><strong>Interaction with child</strong></td>
<td><strong>Interaction with child</strong></td>
<td><strong>Interaction with child</strong></td>
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<tr>
<td>Visual</td>
<td>Dialogue with pupil Visual</td>
<td>Where a child does not do PE due to injury. Falling asleep in school overeating</td>
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<tr>
<td>Disclosed information.</td>
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<tr>
<td>Mental Health</td>
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<td>Group activities</td>
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<td><strong>Formal Surveys</strong></td>
<td><strong>Formal Surveys</strong></td>
<td><strong>Formal Surveys</strong></td>
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<tr>
<td>Survey Indicators</td>
<td>Strengths and difficulties Questionnaires, Risk assessment using psychological formulation</td>
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<td>Self regulation analysis</td>
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<td>Social emotional indicator</td>
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<td><strong>Interagency referral</strong></td>
<td><strong>Interagency referral</strong></td>
<td><strong>Interagency referral</strong></td>
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<tr>
<td>School referral</td>
<td>Personal communication with other professionals who know the child.</td>
<td>Referred by school: appearance, self esteem, abuse evident, poor attendance, academic records</td>
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<tr>
<td><strong>Multi-agency involvement</strong></td>
<td><strong>Multi-agency involvement</strong></td>
<td><strong>Multi-agency involvement</strong></td>
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<tr>
<td>Multi-agency meetings</td>
<td>Transition meeting with primary school</td>
<td>Multi-agency meetings</td>
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<tr>
<td>CAF meetings</td>
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<td>Tracking system</td>
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<tr>
<td>Transition meeting with primary school</td>
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<td>Placement of individual</td>
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<td>School meetings</td>
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The table above shows that there is overlap of categories used to identify children at risk of poor educational outcomes. Across all service providers, data analysis,
knowledge of parent/family, interaction with child, interagency referral and multi-agency involvement are used to identify such children.

As a collective group of professional, there appears to be commonality as to how they identify children at being at risk. However, when one drills down into the data collected, a different picture emerges. The analysis of the specific indicators for children considered to be at risk of poor educational outcomes as used by individual professionals indicates little real consensus as shown in Table 12 below. There was no real consistent use of specific indicators utilised across the professional groups. This may be because of the different roles the professional had within the organisation or due to the type of job or particular focus they had. For example, a Headteacher may use a different set of indicators compared to an Educational Psychologist. Educational professionals interviewed appeared to use a variety of ways to detect risk for poor outcomes depending upon the specific role, position and values they had. For example, three educational professionals used self regulation indicators, two used visual information and two used progress with learning as indicators.

Overall, there are a wide range of indicators evident. Education professionals specified 14, social care 10 and health 12. If one looks at the number of professional using any one of the indicators, the highest is 5 – referral of organisation, followed by visual (4), parental difficulties and self regulation analysis (4). From the data emerging, it seems that health professionals appear to have more commonality with education. Again, this may be explained, in part at least, by the fact that they are more likely to be based in school or have a closer working relationship with the school and can thus access educational records alongside their own specific health records. One representative from social care had a clear crossover with education, whereas others used different indicators.
This may be explained by the role that this person had, that of a Family Worker who was primarily based in school.

Table 12 - Specific indicators used by the professionals for children considered to be at risk of poor outcomes (colours demarcate profession: yellow: education; turquoise: social care; blue: health).

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Education</th>
<th>Social Care</th>
<th>Health</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor attendance</td>
<td>*</td>
<td>*</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Exclusions</td>
<td>*</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Parental difficulties with child</td>
<td>*</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Parental difficulties with themselves</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>4</td>
</tr>
<tr>
<td>Survey Indicators</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>2</td>
</tr>
<tr>
<td>Self regulation analysis</td>
<td>*</td>
<td>*</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>NFER data</td>
<td>*</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Pastoral information</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>3</td>
</tr>
<tr>
<td>Visual information</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>4</td>
</tr>
<tr>
<td>Progress with learning</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>2</td>
</tr>
<tr>
<td>Disclosed information</td>
<td></td>
<td></td>
<td>*</td>
<td>2</td>
</tr>
<tr>
<td>LAC status</td>
<td></td>
<td></td>
<td>*</td>
<td>1</td>
</tr>
<tr>
<td>Personal placement of individual</td>
<td></td>
<td>*</td>
<td>*</td>
<td>2</td>
</tr>
<tr>
<td>Multi-agency meetings</td>
<td></td>
<td>*</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Referral of organisation</td>
<td></td>
<td>*</td>
<td>*</td>
<td>5</td>
</tr>
<tr>
<td>Internal Tracking system</td>
<td></td>
<td>*</td>
<td>*</td>
<td>1</td>
</tr>
<tr>
<td>Overeating</td>
<td></td>
<td>*</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Child health computer system</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Transition meeting with primary school</td>
<td></td>
<td>*</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Assessment using psychological formulation of risk</td>
<td></td>
<td>*</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Stress indicator checklist</td>
<td></td>
<td></td>
<td>*</td>
<td>1</td>
</tr>
</tbody>
</table>
Despite the lack of consistently of indicators used amongst the professionals, what emerges is their variety. This thus appears to ensure children are identified and, hopefully, interventions put in place to reduce risks identified.

e) Professional understanding of the term resilience

Professionals were asked as to their understanding of the term resilience and a summary of responses is given below.

Professional responses from Education

The majority of educational professionals tended to define resilience as having the strength to overcome barriers and having the skills and relationships to overcome such barriers. The ability to ‘bounce back’ and to learn from setbacks was referred to and the essential quality of: “Having optimism and seeing that things can be temporary, and thus not having a pervasive view of failure” (Headteacher 1).

The general consensus of the education professionals regarding resilience was being able to cope with difficult situations and having the strategies to deal with those difficulties. Most education professionals stated that children tended to be resilient but no significant underlying philosophy of this was given. One dissident reference that perhaps stood out was with regard to the relationship of resilience and genetic factors as given by the Educational Psychologist, who focussed specifically on the intrinsic psychological characteristics of a resilient child. The reason for this perhaps rests in the specific in-depth knowledge that the psychologist may have had stemming from requisite training i.e. the scientific study of people, the mind and behaviour (The British Psychological Society).
**Professional responses from Health**

The majority of health professionals utilised a more ‘medical’ approach in their definitions. A few professionals defined resilience as being dependent upon the child’s inner capacity “to mentally cope with adverse or negative feeling” (Clinical Psychologist) and their “ability to endure and to find or extract some meaning for what is happening to them” (Art Psychotherapist). Most health professionals showed an understanding of the aspects of resilience, referring to a range of determinants such as intellectual ability, personal characteristics and temperament:

Different levels of resilience - individual primary attachments, intellectual ability, friendship, access to social activities, temperament; community/social cohesiveness - socially adhesive groups. Strong family connections; primary attachment – good role models, aspirations, societal messages regarding socially responsible behaviour, aspirations they can look to; schools to play a major role in lives – individual teachers; school ethos, future aspirations (Clinical Psychologist).

**Professional responses from Social Care**

The majority of social care professionals viewed resilience as the ability to get through difficult situations, to ‘pick oneself up’, to function and generally get on with life. One professional saw resilience relating particularly to an individual’s social situation:

Having the requisite internal capacity, familial capacity and support capacity to survive and benefit from what is actually on offer (Lead Social Care Manager).

Most social care professionals saw resilience within the context of their own profession for example, one professional referred to the removal of the child from an adverse situation and the ability to “re-establish” self. It was viewed too that children in general were naturally resilient. However, there was one dissident
view in that children could become over resilient and mask true feeling, stating that:

Resilience can be dangerous / damaging as it shadows emotions, children forget what it is like to be happy, angry (Family Support Worker 2).

Aspects of commonality and difference
There were clear areas of commonality between all professionals with regard to their definition of resilience. Most professionals referred to the ability to ‘cope’ and ‘having coping mechanisms.’

Education and social care professionals tended to see resilience as an ability to get through difficult situations or “having strategies to be able, to cope with difficult situations” (Headteacher 2) Health professionals referred to mental capacity, inherent factors and the factors present external to the child to enhance resilience capability. The only educationalist with a comparable view to health was the Educational Psychologist due perhaps from a specific training perspective - a focus on intrinsic psychological characteristics that has roots in the medical profession. The latter referred to resilience as:”the combination of genetic and family factors that enable children to succeed against the odds.”

Conclusion
Although most professionals were able to demonstrate understanding of the social and constitutional origins of resilience, such as levels of family support and temperament, there was little evidence to indicate that they understood the complexity of resilience as the term is used in the research literature: i.e. that resilience has various interlinking factors and multi dimensional relationships
involving the individual, family, community, environment and culture of any given individual at any given time.

f) Professional views on the factors that enable a child to become resilient to the risk factors encountered

The professionals were asked to state the factors that enabled a child to be resilient and the majority were able to identify certain common social and constitutional factors that helped to build resilience.

Professional responses from Education

The majority of professionals focussed on the emotional competencies, cognitive ability and good physical health of the child as contributory factors to building resilience. Some professionals stated that role models had an important role in showing children how things could be in the future, focusing on the strengths and talents of the child, and allowing the child to feel comfortable with other significant adults, such as school staff, in order to express feeling they have. Building a child’s sense of identity, coping skills and understanding of self were also considered important:

Developing optimism within the child ... teaching the child that if they have done something good it is they that has caused it (Headteacher 2).

One professional had a different view:

For some, they are so use to negative feedback they come to expect it so it doesn’t hurt anymore. They may speak to peers who have been in similar situations and find their own way to cope; some that act out or some who stay silent and isolate themselves (Outreach Worker 1).
Professional responses from Health

Professional responses included the importance of school ethos, practical support from agencies and professionals and allowing children to have opportunities to explore their feelings. Most professionals also stressed the importance of role models and significant adults with the underlying context of having stable and caring relationships:

The importance of role models lay in being supportive and in providing a meaningful relationship where the child is not abused, is cared for and one that gives space within the relationship and attention to express …concerns and occupations in a safe way (Horticulturist).

One health professional stated that some children had a self-protection that was natural within a child as experiences factored into the level of resilience a child had - the more life threw at them, the more resilient they became. The professional also stated that children were often ‘too resilient’ (School Counsellor). This was not a view that appeared to be shared by other professionals within health.

Professional responses from Social Care

Most professionals referred to positive relationships; a structured and positive environment; and the importance of competency skills. The importance of a positive role model was regarded as major factor in enabling a child to become resilient to difficulties encountered, referring to the inherent need for a child to have “somebody who commits unconditionally” (Senior Practitioner) - one who would ‘watch them’, or enable the child to ‘learn from them’. The latter believed that children learned to be resilient as opposed to having intrinsic resilience:

In the early days they have suffered from physical, emotional neglect etc. They learn to stop crying and wait. Their mind adjusts to the chaos from an early age. They learn to cope with anxiety, rejection and loss. They learn
early on. They are lost. There is no loving attention, no positives – all negatives. What they gain from a good carer is everything they have never had – it is out of their norm. Strategies and processes are learned early on to deal with the traumas. They learn to stop crying to be fed. They develop a different way of coping, a different way of surviving (Senior Practitioner).

Aspects of commonality and difference
Most professionals across the key service providers appeared to have a common understanding of the factors that enable a child to become resilient and responses referred to positive role models, positive relationships, family bonds, significant others and supportive home life. There was agreement between some of the health and education professionals with respect to factors such as having emotional intelligence, intellectual ability, positive temperament, high aspirations and positive/ successful experiences such as academic success or the ability to shine at something. The majority of professionals recognised the importance of individuals, in whatever setting, for the development of resilience within the child, referring to the importance of the ‘significant other’ in a variety of capacities within or external to the family.

The data indicated that there was a greater correlation of responses between education and health. This may again be explained due to the greater association that health has with the school compared to social care professionals. Social care focussed on resilience developed through the experience of child rather than intrinsic factors.

Conclusion
In the main the professionals tended to focus on the psychological factors of resilience. The professionals all appeared to understand the micro aspects of resilience and there were common references were made with regard to
intelligence, being good at something, being healthy and having family support. There were references too, to meso factors such as the importance of school and access to community resources. There was little real data evident about the importance of the macro factors that impacted on resilience such as access to wider community resources.

g) How professionals build resilience within children

Emerging themes across the professionals groups included the importance of relationship building, both between children and between children and staff; teaching actual competencies, such as compassion and empathy skills, as well as giving experiences designed to build confidence; through developing parenting capacity through courses such as Webster Stratton; and supporting the emotional development of a child, such as building a child’s inner strength.

Professional responses from Education

Education professionals referred to the importance of school management and developing an appropriate ethos within the school setting to ensure children were able to build resilience; teaching teachers to have a responsibility for developing resilience within children through positive classroom management and relationships with pupils. Both Headteachers interviewed believed it was important for their staff to understand their individual influence on, and significance to, children in terms of developing positive relationships and the lasting impact that this might have. The importance of the wider curriculum was also acknowledged, including the explicit teaching of self-regulation and emotional skills to deal with situations that children face, as was creating opportunities within the school setting that allows positive relationships to be developed and for risk taking. The opportunity to develop and teach about empathy was cited as an effective strategy to build resilience, as was the
importance of helping children to understand that difficulties in their lives can be overcome.

**Professional responses from Health**

Most health professionals focussed on the importance of building positive relationships, undertaken through the ‘provision of time and space’ during therapy sessions, meeting with parents / children and through health assessments. Some health professionals cited the importance of promoting opportunities for children to have appropriate social interaction within an integrated setting and one that encouraged ‘self expression.’ Examples cited included circle time, emotional intelligence groups, Webster Stratton parenting course, anger management and art therapy sessions.

The School Nurse stressed the importance of the curriculum and allowing through opportunities to increase pupil success and enjoyment through learning support sessions and through direct lessons, such as delivery of PSHEE with school staff. The latter, however, felt that they did not do as much as they could to build resilience for corporate reasons:

> We don’t do very much, not enough time to put in1:1 time, we tend to sign post quite a lot – CAMHS predominantly and to the Voluntary Sector such as the Refugee and Asylum Support services, homeless services etc. We now follow Public Health agendas and undertake preventative work. We work towards government targets. There is a huge teenage pregnancy problem, therefore schools nurses have to tackle this.

One health professionals stressed the importance of well-evidenced based techniques or strategies used to build resilience:

> There is an individual / retrospective basis relating to psychological formulation – best way to promote resilience is by psychologically healthy
interaction e.g. cognitive behaviour therapy, group work, range of activities (Clinical Psychologist).

Further, strategies deployed must include:

Use of a range of psychological interventions (cognitive behaviour therapy) for anxiety disorders and depression; how we promote effective therapy is not a scattergun approach. We are a specialist service and we use evidence based intervention which is theoretically sound (Clinical Psychologist).

Both the Clinical Psychologist and Art Therapist focussed on the importance of a ‘primary attachment.’ Building resilience through the “notice of metaphor” was consider important by the Horticulturist and thus provides an example of the individual nature of conceptualisation. Developing empathy with the child was also considered important by the latter:

the essential point is thinking together with the child about what they are going through and what it is like for them; witnessing their experience, giving it a sense of meaning – can allow them to cope if someone has listened and heard what they have to say (Horticulturist).

**Professional responses from Social Care**

Most social care professionals focussed on activities that built positive relationships and at how to communicate effectively with peers and adults appropriately:

We have to form relationships / connections with the young person and parent to achieve change in time, positive relationships (Lead Social Care Manager).

The latter also stated that the service built resilience through:
assessment of need, we use a wide range of strategies; most important is assertive practice, making adults responsible for actions, preparing young people for positive choices, we see the damage for poor choices – honest open, non judgmental – fundamental accepting of diversity, respect for human beings e.g. in sex abuse there are complex dynamics, need to salvage parent for them – have to find positive and safe roles, salvage relationships, what risks present to them, empowering them for the future – embedding positive messages, scripted messages...Through assessment of need and need not to be at risk; an analysis which leads to the implementation of a plan for young people. Processes are prescribed.

Some social care professionals cited the importance of supporting children with their academic development and the provision of a curriculum that allowed children to develop appropriate social skills. They also cited their intensive work with identified pupils with regard to developing basic skills and through in-class support.

Teaching children life skills as well as providing a variety of activities and trips to build positive relationships were all ways in which the professionals help to build a child’s resilience. The majority of social care professionals referred to the importance of developing self-esteem and providing opportunities to develop such skills, and encouraging children to look at specific issues. Teaching children requisite skills to do with building and sustaining friendship and how to ‘communicate effectively’ with peers and adults was considered important as was giving children opportunities to relax and have calmness in their lives so that they can open up and talk about things. Furthermore, it was considered important to teach pupils ways of dealing with specific anger issues in order to support the child to ensure that aggression was channelled in a less confrontational way. Some professionals emphasised developing skills such as solution focused techniques and offering different experiences to develop self; providing a context in which to understand bullying, bringing the victim and perpetrator together as a way of dealing with associated issues; opportunities to discuss difficulties in a non-violent...
and non-confrontational way in order to bring resolution. Use of therapy was cited as a way to get children to deal with feelings and stressful situations as was the importance of developing high expectations within children, ensuring that they are valued and their views respected; One social care professionals spoke of the need to accepting the child 'unconditionally.'

Work with parents was also considered imperative in helping children to build their resilience. One professional made the point that because the child has learned resilience; “their true feelings are hidden and forgotten; their task is find the proper feelings of the child [and to] get back in touch with their emotions” (Family Support Worker 2).

**Aspects of commonality and difference**
The majority of professionals agreed on the importance of developing empathy and relationships in building resilience and allowing children to experience positive activities. There were common links with emotional development, curriculum sessions and with working with parents. There is a clear link between health and education in building resilience and provision of specific interventions. The influence of health, especially with regard to intrinsic psychological factors, was far more apparent within education than that of social care. Again, part of this may be explained by the influence of health within the education brief - the rise of therapy within schools as a way to cope with angry children, the use of Webster Stratton to help and support and increase parents competencies dealing with such behaviours and to build positive relationships. Webster Stratton is essentially based on cognitive behaviour therapy. Play, art and horticultural work with children is essentially based on psychotherapy; similarly circle time and developing emotional literacy of children are concepts derived from academic psychological work relating to emotional intelligence (Love et al, 2005). The main
emphasis from the social care professionals tended to be on building skills and the relationships, underpinned by effective communication.

**Conclusion**

The findings indicated that resilience tended to be built through a psychology perspective. The one main difference stemmed from health with a professional stating that “the best way to promote resilience is by psychologically healthy interaction” (Clinical Psychologist). Health also referenced specific therapies that were utilised to address particular needs. Cognitive Based Therapy was referred to as an example of one of the range of evidence based techniques used for psychological intervention for anxiety disorder and depression. Thus, the focus is on a disorder that needs to be treated. It serves to perhaps illustrate the different conceptualisation that professionals have of children and that health provides interventions focus predominantly on a pathological model.

**h) Multi-agency links professionals have regarding children at risk of poor educational outcomes**

Links with other key children related agencies was discussed with the professionals and their responses relating to multi-agency working is best recorded through tabular form. The table below shows the different agencies that the professionals interviewed worked with on a regular basis.

**Table 13 -The different agencies the professionals specified that they regularly worked with**

<table>
<thead>
<tr>
<th>Agencies</th>
<th>Education</th>
<th>Health</th>
<th>Social care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schools</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Social Care</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>CAMHS</td>
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<tr>
<td>School Nurse /Doctor</td>
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<tr>
<td>EPS</td>
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<tr>
<td>School Attendance</td>
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<tr>
<td>Police</td>
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<tr>
<td>NSPCC/ Catholic Rescue / Banardos</td>
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<tr>
<td>Other Voluntary Organisations</td>
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<td>YOT</td>
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<tr>
<td>Speech &amp; Language</td>
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<tr>
<td>Bereavement Service</td>
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<tr>
<td>Connexions</td>
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<tr>
<td>Counsellors</td>
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<tr>
<td>Play Therapists</td>
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<tr>
<td>Paediatricians</td>
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<tr>
<td>LA Support</td>
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<td>Sure Start</td>
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<tr>
<td>Adult Education service</td>
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<td>Housing</td>
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<td></td>
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<tr>
<td>LAC Team</td>
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<tr>
<td>General Practitioners</td>
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</tbody>
</table>

Multi-agency working and involvement of agencies amongst the professionals is broad. The need for good multi-agency relationships is clearly considered essential if effective delivery of service is to be acquired, if only to ensure non duplication of services. The role of the GP is perhaps interesting to note - only through health is there apparent dialogue despite this person having key knowledge of the family. The professionals were asked to comment as to the effectiveness of the multi-agency working. There was a mixed response as to effectiveness from an individual and corporate point of view.

**Professional responses from Education**

Some education professionals stated that multi-agency working was poor in places and often dependent upon the allocated individual and not the service:
Often to get something I have to go to the Principal Officer. Service provision is all very individual – how good your particular school nurse is etc. Systems and policies are not good and are often not in place therefore rendering provision and quality of service very frustrating (Headteacher 1).

Issues that most professionals commented on included poor communication, sharing of information, lack of holistic planning, different pay and conditions within multi-agency teams. The organisational and cultural difficulties are evident in the following extract:

[Multi-agency working is] poor in certain parts; we are meant to be moving towards multi-agency teams. As a service, we are now based with School Attendance Improvement Service and Educational Psychology Service for the District – bringing us altogether. We talk to each other each day and this is working well – it is better as we talk to each other not just on the phone. We recognise each other now. It took a little while to find out what we all actually do. Eventually we need all to move on to the same conditions of service. At the moment some staff are on teacher conditions, some work all year round, some do different hours. There are no real major problems. People do however stick together and we need to break this barrier down and relate better to each other’s profession. Walls are still up and we quickly revert to I am a Teacher; you are an Attendance Officer (Behaviour Support Specialist).

Both Outreach Workers stated that multi-agency links were generally positive and “effective.” However, Outreach Worker 2 was particularly critical of social care stating:

...the relationship is poor, no relationship at all. I go straight to the top when things are dire but even then it is like banging your head against a brick wall. Parents – poor or drug users need to be looked at more carefully as they are vulnerable. They need to be looked at more carefully by social services... forget social care – child placed at home even when they shouldn’t be; endangering children. They have made it more acceptable to neglect children
and leave them in situations. Most people know how to play Social Services – no consistency – Social Services have not the time to check up on things and children are left dangerous situations.

There was recognition too of the benefits of multi-agency working and the importance of working together for the benefit of the child:

You cannot fulfil needs of child without other services; you cannot do this on your own, need to refer on (Education Outreach Worker 1).

Further,

There is some multi-agency working. Looking at the child as a whole; ensuring a multi-agency approach to enable the improved well being of individuals; having clear plans to support and develop holistically the child and their long term social inclusion (Headteacher 2).

Professional responses from Health

Some health professionals felt that there was a good network of professionals though there were some obvious frustrations evident:

Teachers and Social Workers have little understanding of therapeutic processes – they understand notion but not process (Horticulturist).

It was stated that relationships between service providers were improving but “there are still problems and frustrations e.g. getting hold of people. However, there is far more information sharing (School Nurse).

“It’s getting better,” was the general view amongst health professionals, though one particular point made by the Clinical Psychologist perhaps revealed certain frustrations felt:
multi-agency working, breaking down barriers – laudable ideas: concern that the process does not lose sight of what we are here for – stuck in the mire of bureaucracy due to professional boundaries.

Professional responses from Social Care

The view of multi-agency working amongst social care workers was somewhat different. Social care professionals stated that liaison was very effective, (LAC 2) and even “extremely effective.” (Lead Social Care Manager). The Family Support Worker 2 stated:

We can offer a good package of support and intensive support has improved outcomes. We can access a statement and ensure quick interventions with other services through a multi-agency approach. We are effective and outcomes are improved, specialists more involved e.g. STDs, Pregnancy.

There was one dissenting view which is of perhaps worthy of note:

[There is] not as much communication as there should be – so many people are involved in one child and therefore someone gets missed out and I don’t realise. Sometimes, there are too many people working with one child or family and this leads to duplication (Family Support Worker 1).

The Lead Social Care Manager recognised the difficulties of moving towards a fully integrated service as well as the benefits stating:

... the emphasis being on multi agencies teams across disciplines – all to be a part of a multi-agency team. It needs to be a well organised, transparent service. There are risks with dismantling the service – must not dismantle relatively safe child protection process or have managers that do not understand the processes that have to be followed. Gains are to be had have
great potential but it is a complex and difficult operation not to be underestimated

Comments collated from the interviews indicating cultural and organisational difficulties are illustrated below and indicate perhaps the depth of criticism from the different key services.

**Social Care about Education**

Teaching is a problem – not adequate delivery of the curriculum and the curriculum itself does not always accommodate the children (Family Support Worker 1).

**Health about Education**

[Pupils are often] Being disrespected by teachers - hasty to make decisions on what they see – not the build up to the situation. They are not able to express their situation - they are sent out of the lesson – not investigated by the teacher – they are resented by the teacher. Frustration and injustice of non adult intervention - teachers become almost part of the bullying process. ..Teachers unable to control the class – shouting, creates an atmosphere where no one can work; bullying in the classroom. They are disrespectful so why respect them? (Counsellor)

**Aspects of commonality and difference**

Across all professionals there were both positive and negative comments with regard to effectiveness of multi-agency working. There was recognition by the majority of professionals that multi-agency working needed to improve especially with regard to relationships and working practices:

People stick together and we need to break this barrier down and relate better to each others’ profession... there are still issues over communication, sharing of information and holistic planning (Education Behaviour Specialist).
There were aspects of organisational and cultural difficulties from having different conditions of service, problems of sharing information and the admission that of recognising other peoples’ worth.

Across the services, there was recognition of the importance of working collaboratively. However, there appeared to be a greater frustration amongst educational professionals compared to the other organisations, with regard to social care support – perhaps because it is even more data and target driven than health and education:

We are now sophisticated at analysing hard data as well as qualitative data... We are effective and outcomes are improved. (Lead Social Care Manager)

Certainly the frequency of targets, specific actions relating to specific agendas are far more readily referenced than education. Perhaps worthy of note was the perceived aspect of duplication - something that multi-agency working was meant to eradicate in order to ensure effective service delivery.

Conclusion
There was no real consensus with regard to multi-agency effectiveness. Comments tended to be made in relation to specific working partnerships or particular working experiences. Some professionals believed that multi-agency work was successful, others not so. There were more references to barriers that can inhibit collaborative practice between agencies across the key children’s services compared to facilitators.

It appeared that the effectiveness of multi-agency working was often down to individual people involved rather than due to systems or structures being in place. The value of multi-agency working was clearly evident in the responses given but
there were clear organisational and cultural structures that impeded actual working.

**Overarching themes and issues arising from professional interviews**

The main themes emerging from the analysis of professional interviews involve a) professional conceptualisations through discourse; b) lack of a common language; and c) critical responses towards other service providers due to cultural and organisational difficulties.

**a) Professional conceptualisation**

Professionals interviewed had a tendency to emphasise their own knowledge perspectives. With education, the emphasis is on learning outcomes and how difficulties within the home and community impact on learning and performance in tests or qualifications. With health, there is the use their own ‘pathologising’ framework, for example, through the use of phrases such as ‘disorders of impediment,’ and ‘depression’. Health professionals also tended to focus on the health related aspects of poverty - the medical impact of alcohol and drugs and the psychological impact of trauma and emotional difficulties aspects that thereafter impact on life chances and poor educational outcomes. Health professionals referred to their ‘specialist knowledge’ with interventions based on ‘empirical evidence.’ With social care, there is the dominance of the family and of regular referencing to the ‘Children’s Act 1989 and the ‘Section 3.1 threshold relating to child protection.’ Social care professionals’ focus appears to be far more procedure driven, (e.g. with emphasis on “prescribed processes” (Lead Social Care Manager)) and bound by a legal framework, compared to health and education.
b) Lack of a common language

Emerging from the findings is the use of the different technical professional language that the professionals across the services have. For example, social care and education professionals frequently referred to ‘issues’ and ‘difficulties’ whereas health tended to utilize specific medical language referring, for example, ‘stress indicators’ and ‘congenital factors.’ The specific medical language used by health professionals was comparatively extensive and included a variety of medical/clinical references. There was some cross over between health and education with regard to the use of “indicators.” This was particularly seen with reference to social and emotional indicators. However, this may be attributed to the close liaison between health and education in relation to the Healthy Schools Project.

The table below indicates the specific professional language or references recorded throughout the interview process. All professionals used professional terminology or jargon but the table below clearly shows the greater frequency of medical referencing.

<table>
<thead>
<tr>
<th>Table 14 Specific language used by the professionals during interview</th>
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<tbody>
<tr>
<td><strong>Education references</strong></td>
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<tr>
<td>Preferred learning style</td>
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<td>Pupil tracking</td>
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<tr>
<td>Transition</td>
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<td>Learning need</td>
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<td>Poor SATs results</td>
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<td>Exclusions</td>
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<td>High achieving schools</td>
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<td>Unofficial exclusions</td>
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<td>Reduced timetables</td>
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<td>NFER information</td>
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<td>Performance</td>
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The pathologising of the child is clearly evident in the language references stemming from interview discourse particular amongst health professionals, and to a lesser extent the Educational Psychologist and Headteachers, who referred to self regulation and emotional well-being. Social care language tended to related to statutory agendas.

The specific language that professionals used was especially evident when talking about interventions. This may be due to the fact that some of the interventions were underpinned by a focus on internal psychological factors rather than external socio-economic ones – for example, the importance of emotional well being. Health strategies typically included medical or psychological related interventions which were evidence based and thus professionals utilised specific language; the deeper the theoretical understanding of, for example, resilience, the greater the respective answers were influenced by more medical and/or clinical terms.
c) Critical responses towards other service providers

The difficulties of multi-agency working and effectiveness were clearly demonstrated within the data collected. A variety of reasons for this were given across the professional groups, organisational and cultural, including misunderstanding of roles and responsibilities, service provision, and difficulties with bureaucracy. Multi-agency effectiveness appeared to be dependent upon the actual individual rather than corporate services provision and structures. One reason for the frustration experienced by education professionals regarding social care support, for example, is the latter’s data driven agenda and the constant reminder of how actions are determined: “[through] performance measured audits, specific responsibilities e.g. Crime and Disorder agenda” (Social Care Manager).

The findings from this section indicate a variety of difficulties in terms of multi-agency collaboration that corresponds well to the review of literature in relation to conceptualisation, culture, structure and professional roles. Stage 2 of data analysis is presented in the next section.
Stage 2  Questionnaire responses

An overview
The following section focuses on the analysis of case study data stemming from a structured questionnaire given to the key practitioners working with five selected pupils at risk of poor educational outcomes. It seeks to ascertain how practitioners’ understandings of risks for poor educational outcomes reflect in or impact on intervention strategies deployed in order to answer the following questions: Do the different practitioners perceive pupils in the same way in terms of a) risks faced, b) their understanding of resilience and factors that foster resilience; and c) how they build resilience? The section also looks at coherence and effectiveness of intervention and multi-agency working in a practical setting.

Context
The following information is a summary of practitioner views relating to their direct individual involvement with one or two of the five case study pupils. The information was gained through school held data and through the use of a structured questionnaire. The practitioners, essentially fieldworkers, are all line managed by the senior professionals interviewed previously, with the exception of the nurse and horticulturist, and regarded as the key practitioners involved with the individual pupil. The Nurse and Horticulturist were interviewed previously about general involvement with vulnerable pupils but the questionnaires referred to specific pupils.

The aim of the questionnaire, in relation to the individual child and from their own perspective, was to ascertain a) practitioner conception of risks for poor educational outcomes; b) how they respond to such perceived risks; c) how practitioners understand i) the term resilience, ii) factors that foster resilience and
iii) how they build resilience; d) the similarities and differences between practitioners in their understanding and responses, and e) if provision made is coherent, coordinated, organised and managed effectively.

This stage of findings and discussion analysis is organized in the following way: Section A focuses on individual case study pupils; Section B analyses the practitioners’ general understanding of risks and of resilience; Section C considers the coordination and coherence of provision; Section D focuses on multi-agency working which is then followed by a conclusion to this section’s findings.

**Section A: Individual Case Study Pupils**

Five pupils at risk of poor educational outcomes were used as case studies to exemplify actual practitioner involvement. There is a brief vignette for each child which gives; the pupil’s background; a school summary; the specific risks factors and protective factors identified by practitioners; and how practitioners have built resilience to ensure risks faced are lessened or reduced. This is then followed by a more detailed focus on how the practitioners view the child and how typical the child is in school and within the wider community i.e. were there other children in the school who had a similar profile; how the practitioners respond to such perceived risks; and if interventions deployed are effective in reducing risks and building resilience.

In each case study the corresponding data is reviewed to consider aspects of commonality and difference of conceptual understanding and how such understanding impact on interventions.
Individual Pupil Case Studies

Pupil A

Background: Pupil A is an unaccompanied Refugee and Asylum seeking child having come to England with a slightly older sibling. He is a Looked After pupil, voluntarily accommodated within the Local Authority.

School summary: Upon transition and throughout Year 7-8, records show that the pupil had a good attendance record. During Year 7, there were two sporadic incidents of violence towards peers but no recorded fixed term exclusions. During Years 7 and 8, statutory six month reviews were attended by key professionals within the school. The pupil is further monitored by an outside of the city LAC Regulator and the school is held accountable in terms of ensuring the standard of education is appropriate and that the pupil is making progress. Termly reports on attainment, progress and attendance are submitted to the LAC Regulator. With regard to the statutory reviews, over the two year period studied certain aspects appear to be recurrent; non attendance to all reviews by Pupil A and not wanting to contact relatives in the country of origin for fear of reprisals. Records indicate that the pupil did not want agency support in contacting relatives.

Specific risks factors identified by practitioners: Cultural difference; underachievement and emotional difficulties; Looked After and Refugee Asylum status.

Protective factors identified by practitioners: Engaging personality, able to form good relationships; good at sport; extended peer network; stability of carers and school; high cognitive ability; involvement in extracurricular activities; positive self esteem.

How practitioners have built resilience to ensure risks faced are lessened or reduced: Counselling, pastoral support, positive reaffirmations; allowing an outlet through therapeutic intervention.
How the child is viewed by practitioners involved

Education

From the data emerging from the questionnaires, the educational practitioners recognise the some of the child’s difficulties regarding his “battle with the differences he faces living in this country without the support of his parents.” The child is viewed as a typical pupil within the school, with regard to those with English as a second language and representative of the school’s multi ethnic community:

There are significant numbers of pupils in the Year group and in the school, who, like Pupil A, have come from this area of the world and have shared his experiences (Head of Year).

Pupil A is referred to as ‘underachieving’ by the educational practitioners, explained through the pupil being easily led into unacceptable behaviour by friends rather than concentrating on work. This is considered a negative quality and, as such, is admonished for this. The educational practitioners tend to focus on concerns arising from academic data and poor attainment and appear to pay little real regard to inherent emotional issues stemming from being Looked After and his refugee asylum seeking status other than when it impacts directly on attainment through poor behaviour.

Health

Health workers, on the other hand, focus predominantly on the child’s emotional needs and view progress made in relation to social and emotional development. The child is considered by the Horticulturist as “very untypical, as Pupil A is insightful, resilient, emotionally competent and a pseudo adult”. The School Nurse states that the child “is much more than a Looked After Child and is distinctive because of their unaccompanied Refugee and asylum status.”
The Horticulturist states that the child is very bright but a different construct is formed with regard to their current level of underachievement; it is explained in relation to ‘the relevance of the subjects perceived by the pupil’ within the context of his background experiences. The Horticulturist does not see the child as being ‘easily led’ but views it as ‘wanting to be like everyone else’ and as such is an understandable characteristic given the trauma the child has been through and thus a natural response in relation to psychological development and reaction of past events. The practitioner thus states:

Pupil A gives classic presentation of wishing to forget... Most who have experienced the loss and disruption and trauma that he has are far less able to cope with day to day life than he is, and most have less insight into their situation.

The Nurse also states that the child wants stability due to their emotional issues relating to being an unaccompanied youngster from a war torn country. Pupil A “desperately wants to fit in and wants to be like everyone else – and wants to be the same as his peers.” Both health practitioners are of the view that he is very different from other pupils in the school.

**How practitioners respond to such perceived risks**

The support given to Pupil A varies. From education, support is geared around informal counseling and pastoral support e.g. by the Form Tutor “through talking to the pupil” and counseling in response to behavioural difficulties. The Horticultural Therapist gives support according to “disclosures by and presentations of the pupil.” The latter uses therapy as a means to allow the child to come to terms with the past and to allow the child to find his own person.
Effectiveness of interventions to reduce risks and build resilience

There was a mixed response as to effectiveness of interventions that were used to support the child and there is a clear difference in the outcomes expected. The education practitioners mainly focussed on behaviour at school:

On many occasions it seems as though there has been no effect. However, it is soon realized that the intervention is actually appreciated. He always apologises sincerely when he behaves inappropriately; he is able to explain his behaviour – the rights and wrongs and give unaided ways of resolving and changing the situation (Form Tutor).

The School Nurse stated that effectiveness of interventions were apparent but attributed this to procedures being in place rather than a more tangible outcome: “LAC reviews – effective in that they pull all the issues together.” The Horticulturist indicated that interventions deployed were partially effective in so much as the child had taken advantage of the therapeutic strategy deployed:

We provided a forum for Pupil A to explore several important issues that he hadn’t previously discussed. Specifically, he disclosed information about his past that he hadn’t previously verbalized. More generally we gave him ‘permission’ to feel the way he did /does, and reassure him that this was a normal response

At times the practitioners across the service providers appear to be pulling in different directions. The focus for the Horticulturist was to allow the child to gradually come to terms with the trauma of losing parents and understanding for the need to ‘forget’. This appeared contrary to what the Form Teacher wanted to achieve:

By reminding him of the values he was brought up with – the wish his parents would have for him to stick to them such as manners, respect, kindness, friendliness and control.
Pupil B

**Background:** Pupil B has a Statement of Special Educational Needs and is a Looked After child. Reports from the school indicate that Pupil B is seen as having behavioural, emotional and social difficulties in addition to significant learning difficulties with regard to basic word knowledge / language development, basic number and computational skills. The pupil has auditory short term memory difficulties. The school considers that Pupil B finds it hard to form appropriate relationships with adults and was demanding of adult attention. It was reported that Pupil B can be aggressive when challenged by peers and that their social integration is ‘problematic.’ An educational psychologist stated that Pupil B demonstrated:

...a high level of distractibility, impulsivity...Poor academic progress appears to stem from a combination of learning and emotional difficulties, exacerbated by a number of changes in Pupil B’s life (in and outside school).

**School summary:** During Year 7 and 8, the academic gap between the pupil and peers appears to widen significantly, as evidenced through school attainment data held. The pupil had experienced significant trauma over the last three years involving family change of placement. It was reported by the Social Worker that Pupil B appears not to fully comprehend the difficulties of familial ties and court responsibilities and this has led to frustration, manifested in aggressive and non appropriate actions. It was recognised by some of practitioners involved that the pupil is unable to always verbalise feelings and emotions. During Year 7 -8, the pupil has had two fixed term exclusions for assaulting a pupil and for assaulting a teacher.

**Specific risks factors identified by practitioners:** Learning and behavioural difficulties, poor emotional regulation; vulnerability; emotionally young; inappropriate relationships; Looked After status; Statemented.
Protective factors identified by practitioners: Stability and support of adults; positive temperament; engaging personality; strong bond with older siblings; able to form positive relationships with peers; engages readily in non academic extra-curricular activities such as cheerleading and dance.

How practitioners have built resilience to ensure risks faced are lessened or reduced: Use of praise; inclusion; pastoral support; help in building appropriate relationships; building confidence and control of her life; social emotional programme; counselling; curriculum support; specific PSHEE support

How the child is viewed by practitioners involved

Education

Education practitioners appear to view her main difficulties as those involving relationships. The Teaching Assistant states that. “I am aware she is very vulnerable and has not matured as much as others in her year group.” This perhaps indicates that they consider that the child will ‘grow up.’ The pupil is referred to as being “emotionally young” and one who “struggles to comprehend some social situations” (Form Tutor).

I feel that this pupil could end up quite lonely. The pupil does not understand the meaning of having friendships with others. The pupil’s feelings are easily hurt (Teaching Assistant).

There is recognition amongst most practitioners that the child has behavioural and emotional difficulties. The pupil is perceived as one who “has issues with her anger” (Form Tutor) and is unable to regulate emotions appropriately. Some practitioners see the pupil as one of many “regarding such things as attitude, ability and lacking confidence” (Student Support Officer).

The educational focus is on the child’s emotional and behavioural needs as these are viewed as the main barrier to academic progress. The child’s low ability is
recognised by the education practitioners involved with the child, but there is little evidence to suggest that much is done to address such needs as the latter appear to focus on behaviour and not on the learning requirements i.e. the focus is on school behaviour related issues.

**Health**

Health practitioners appear to pathologise the child’s difficulties and see her as being disabled. The Counsellor refers to issues of “displacement” and “insecure attachments.” The School Nurse states that the child is very different from other children within the school due to her “significant learning difficulties – she is very low ability which renders her far more vulnerable and distinctive.” The Nurse states:

Pupil B needs to learn how to function in social situations; she needs social and independent skills – she has significant needs that require specialist intervention.

Thus, it is perhaps a problem that needs to be fixed.

**Social care**

Social care practitioners recognise the child’s learning and behavioural difficulties and one practitioner refers to her “immature behaviour and impulsivity” (LAC Worker). The social care practitioners view the child in respect of child protection and their increasing vulnerability within the community.

The pupil is very vulnerable because of her learning difficulties and is an easy target for paedophiles, possible subject to abuse. The pupil has no stranger danger strategies (Social Care Worker).

The Social Care Worker has a different opinion of the child compared to the Counsellor. Rather than a detachment difficulty, the latter states:
She is always interested in other people and she can empathise with others – she was very upset about the girl who was shot – she gets upset about events around this – how she died and what had happened – She knew her and it affected her deeply.

Another social care practitioner states that:

...the pupil is very distinctive. Not like any other I have supported. This pupil’ emotionally childlike innocence displays a vulnerability that could be taken for granted as they get older. This pupil has not yet fully grasped how to deal with and communicate difficult situations or find solutions independently (Looked After Worker)

How practitioners respond to such perceived risks

For education practitioners, functioning in school is the priority and the child’s relationships are viewed only really within the context of her year group and peers and how this impacts on attainment. The remit of the school nurse is primarily to access additional specialist services or through specific interventions so that the child can function safely in society. The latter is of the view that:

She is very vulnerable and could be easily taken advantage of. She needs social and independent skills. She is not able to make informed judgments’.

The social care practitioners appear to have a wider understanding of the child and look to undertake interventions with regard to learning and social support and aim to ensure the child is able to be safe within the community.

The practitioners have mixed views as to how typical the pupil is within the school. Some practitioners view the child as not at all typical of those they usually work and this is qualified by practitioner references to the child’s learning
difficulties but not so typical by others, e.g. “The Pupil is very distinctive. Not like any other I have supported” (LAC Worker); “The pupil is very different” (School Nurse).

Individual decisions as to support given were evident from the questionnaires. For example, the Learning Mentor stated support was given through, “discussions with the individual and my own observations.” Likewise, the Student Support Officer states “through my discussion with the pupil.” In the main however, support in school was determined through the SENCo and special needs team (albeit, according to the Counsellor; “on a sporadic basis as she was seen in times of high crisis or when things were going wrong”).

**Effectiveness of interventions to reduce risks and build resilience**

There is a mixed response from the practitioners as to effectiveness of interventions, such as counselling, individual pastoral support and academic support.

Education practitioners feel that the intervention is effective as the child’s emotions are better regulated. Education practitioners focus on effectiveness in terms of the child being more readily able to behave better in school and in “managing her emotions more effectively” (Learning Mentor). One practitioner stated that the child resolves conflict in a much more positive manner and no longer “gets emotional when others make comments” (Teaching Assistant). Further:

The pupil enjoys company more and will now at times express her feelings in a calmer manner. There is still the odd outburst but she is more in control and willing to share her feelings. I think the pupil feels secure that she has many people to turn to (Student Support Officer).
The Head of Year states that interventions are effective based on the fact that the child is:

more able to form positive relationships with most of her teachers and is popular with her peers. Her academic levels in English, maths and science are low, but she is making steady progress.

Health practitioners are of a different opinion and suggest that while specific issues relating to Sex and Relationship Education (SRE) have been addressed, the underlying innate difficulties are still dominant and thus individual needs are still unmet. The School Nurse refers to the success of interventions in terms of LAC and SEN reviews, health assessments and addressing specific needs such as specific “SRE / Puberty needs through planned 1:1 sessions including hygiene.” However, the Counsellor involved states that interventions are limited:

Just enough to get her through the moment but nothing substantially enough for a shift of mentality or major help with life crisis.

Social care practitioners have a mixed response. The work undertaken regarding emotional regulation has led to the child being:

now more able to seek out identified name staff in school. If the child arrives to school upset, she goes to member of staff to calm down or to regain a more positive mood (LAC Worker).

Further, the Social Worker refers to specific issues as being partially addressed such as the relating to work undertaken on “SRE, stranger awareness, safe within the home.” and with regard to the work undertaken with the family:

I can make parent have a better understanding of how to meet her needs – I have worked with dad on stranger danger, road safety etc. I have acted as a
support worker going in about this –what to do, able to monitor awareness. Dad has to have insight into her difficulties and to protect her due to her vulnerability.

The Social Worker recognises that more really needs to be done:

I have not had time to support 1-1 as much I would have liked but have been able to engage other agencies.

There was consensus amongst the practitioners that often support came through:

a plan ... informed by agencies – health, education, LA, carers which identify needs and how they can be best met. The pupil is under a Statutory Care Order to the Local Authority - there is a multi-agency approach to meeting her needs (Social Worker).

The strategies appear to be coordinated only in so far that the child is reviewed regularly through statutory meetings relating to SEN and being Looked After.

**Pupil C**

**Brief background:** Pupil C was identified at transition as a very vulnerable pupil with an undiagnosed Autistic Spectrum Disorder. The pupil was at school action plus upon transition. There had been no educational psychology involvement at primary school. The pupil was referred by the secondary school to the Educational Psychologist (EP) in January 2007. The pupil had also been raised by the EP attached to the Social Communication Assessment and Interaction Team (attached to clinical psychology). The pupil presented as a friendly and chatty child but one who did not necessarily understand social boundaries.

**School summary:** It was initially reported by the primary school that the pupil has moderate learning difficulties as well as an undiagnosed autistic spectrum
disorder. The WISC IV report indicated that assessment of verbal comprehension, perceptual reasoning, working memory and processing speed are all significantly low. The full intelligence quotient score indicated that the pupil has learning difficulties of a ‘significant nature.’ The tests indicated that although the pupil often made literal responses, the pupil could correctly identify feelings. The Clinical Psychologist, in March 2007, reported that the pupil has a diagnosis of Autistic Spectrum Disorder and severe learning difficulties. The latter recommended that the pupil’s social and educational needs would best be addressed within specialist provision and that the pupil would be adversely affected within a mainstream environment. At a subsequent multi-agency review in May 2007, it was agreed by school and clinical psychology that, given the pupil’s level of vulnerability and significant social and educational need, specialist provision should be sought. However, the Local Authority representative and Educational Psychologist did not attend the meeting, nor was the SENCO invited. Thus, no subsequent action was taken. Clinical and educational psychology involvement led to no specific agreement about how to meet the needs of this pupil.

**Specific risks factors identified by practitioners:** Peer relationships; alienation from peers, social isolation; learning difficulties, social and communication difficulties due to ASD; mental health issues; lack of social skills.

**Protective factors identified by practitioners:** Stable and supportive family; positive relationship with adults.

**How practitioners have built resilience to ensure risks faced are lessened or reduced:** Pastoral and curriculum support; creating a safe environment in school; developing self esteem and confidence; counselling; developing her ability to take decisions; building on past successes and positive changes that have activated positive outcomes.
How the child is viewed by practitioners involved

The questionnaire elicited fewer responses compared to other case studies undertaken. One of the education practitioners appeared to misinterpret the questions. Thus information is limited.

Education

Education practitioners view the child as one who is alienated from her peers through their lack of understanding of the child’s ‘condition and needs.’ The pupil is regarded as not coping with the curriculum and one who “teachers find difficult to teach.” One education practitioner stated that the child had “bizarre behaviour and body language” (Behaviour Support). The Form Tutor sees the pupil as one with a lack of social understanding, rendering her particularly vulnerable at unstructured times.

Health

The School Nurse reported that the pupil “really struggles with social integration and is at risk of possible isolation due to having little empathy with others, few friendships, and little social understanding. The latter stated that having a diagnosis helps the child as this would enable the family to access support networks such as the ASD Society. The Nurse sees the child in terms of her social communication difficulties especially in the context of the community: “Vulnerability has no social impact and thus little community support for such pupils.”

The Counsellor views the child as having a “psychological disorder” and refers to the child:
As a young person with mild autism, Social clues are misinterpreted by the pupil. Her social responsiveness would often be misplaced creating difficult situations every time her actions/reactions do not fit.

**How practitioners respond to such perceived risks**

Support to address perceived risks in school appears to be based around curriculum access, building relationships and social integration. The Form Tutor addresses behaviour issues through setting small, achievable goals:

I have made use of a daily target sheet, continually reaffirming practical goals that she can reach, i.e. ignoring other pupils silly behaviour, not getting upset when pupils call her names, being on time for class and staying there, not using the toilet as an excuse to wander around the school, if she is upset with pupils or staff she is able to come to the classroom and not leave the school.

However, the report card used by the Form Tutor to monitor the pupil and to reinforce success became a source of significant stress for the pupil as if the latter did not get full marks it became a huge source of worry for her. The pastoral support offered by the Tutor is significant and the latter becomes a trusted adult in the child’s school life, building a positive relationship as well as the child’s self esteem and confidence. In terms of academic support the pupil access a high degree of in class support, focused on ensuring the pupil stays on task and makes incremental progress. There is no evidence from the questionnaires as to provision to address basic skills.

Relationship building is also provided by the School Nurse as another person to “talk to.” The Counsellor focuses on supporting the child to “make her own decisions and also take responsibility for her own actions.” The latter also states:
We spend a substantial amount of time to learn how to leave the autistic ‘sticker’ aside and focus on her own individual personality and success had in past and present times.

**Effectiveness of interventions to reduce risks and build resilience**

Support allocated to Pupil C is mainly determined by the internal school resources available. There is frequent dialogue with home and the Form Tutor regularly seeks advice from CAMHS as to how to deal with specific situations as and when they arise. Furthermore, the Tutor informs CAMHS of particular concerns that the school has with the pupil e.g. wishing to be dead, theft of phones, episodes of distress etc. However, there is no regular pattern to meetings or reviews or to assess effectiveness of support.

With Pupil C, intervention is determined by the Tutor’s observation of “obvious distress... the best thing I could do was to give her security by staying with me in my room.” The latter states that interventions have been effective as “I have provided her with safety and security.”

The involvement of the Form Tutor is reported by the school as not being part of a coordinated approach to the support the child, i.e. the Tutor appeared to be working in isolation with the clinical psychologist, leading to no overall coordinated provision with regard to multi-agency involvement. Indeed, the lack of ASD understanding by the Tutor contributed initially to the child’s overall stress. This was addressed over time with the Form Tutor having to take significant amount of advice internally and externally from CAMHS to fully understand the child’s difficulties.

The Behaviour Support Specialist states that intervention is “done in negotiation with the child.” But as to effectiveness:
It has been informally reported that the child is doing better but with identification monitoring and evaluations systems in place it would be possible to give greater detail (Behaviour Support Specialist).

There is similar autonomy of the Counsellor’s intervention, determined through “own understanding of autism working with social clues and cognitive dissonance.” With regard to effectives the Counsellor states:

The pupil was able to handle situations much better and focused on what worked in the past while bearing in mind what did not work at times.

The School Nurse indicates that support given has been through:

the broad referral mechanisms for specialist support through referral to CAMHS and Counselling provision such as 1:1 planned PHSE - SRE / Puberty needs including hygiene. However the Nurse refers to the fact that she is “not in school regularly enough for appointments made available.”

It appears that despite being exceptionally vulnerable, socially and academically, the support provided for Pupil C is not regulated, nor is there much evidence of coordination or planned strategic intervention. Thus, with regard to effectiveness of interventions utilised by practitioners across the key children’s services, no real conclusions are reached as the responses are too generic to reach a valid conclusion.

**Pupil D**

**Brief background:** Upon transition the pupil had a statement for Attention Deficit Hyperactivity Disorder, for which medication is taken, and emotional and behavioural difficulties. It was reported by the primary school staff that her
attitude to learning had greatly improved and had made good progress in all areas of the curriculum. It was reported that the pupil had only recently reintegrated into a mainstream primary school. The primary school reported that the pupil is capable of behaving well and can be kind and generous to others but behaviour exhibited by this pupil can be one of aggression and verbal abuse.

**School summary:** During Years 7 and 8, pastoral records indicate that the pupil found unstructured times difficult to deal with and often presented as angry, upset or frustrated, manifesting in shouting, swearing and physical aggression. The pupil has a fluctuating hearing loss, but school reports that coordination is good and there were no difficulties with motor skills. Records held by the school indicated that presenting difficulties included; demanding negative attention from adults, refusal to follow instructions; aggressive behaviour; inappropriate language; difficulty verbalizing needs, limited concentration and obsessive eating. The Educational Psychology report made available upon transition indicated that the pupil experienced general learning difficulties which were considered by the school to, in part; explain possible reluctance to engage in learning process. It was evident from the files pertaining to Pupil D that the pupil had been placed upon the Child Protection register for physical abuse. This had not been referenced to at transition planning meetings nor that had the child experienced a particularly traumatic bereavement. Throughout Year 7 and 8, pastoral records indicate that Pupil D has presented as verbally and physically aggressive to staff and pupils; significant incidents of bullying and several fixed term exclusions. It was reported that the pupil often had fixations upon other pupils, usually of a negative type. There was evidence that there has been dialogue with the clinical psychology service through written reports and through parent liaison. It was reported that clinical psychology has not attended formal review meetings with the school. The school reported that the relationship between school and home is often fractious due to behavioural difficulties resulting in exclusion and the pressure that this put on the home environment. School reported that at times it was evident through
behaviour displayed that the pupil has not taken medication required to help control her ADHD. It was reported that Pupil D has had many difficulties with peers in school and within the wider community. The pupil is considered to be very reliant upon a sibling within the school and that she has made only one or two friends.

**Specific risks factors identified by practitioners:** Low self esteem, difficulty in understanding social situations; forming relationships with adults and peers; ADHD, behavioural and learning difficulties; alienation from peers; potential gang involvement and anti social behaviour.

**Protective factors identified by practitioners:** Support of family; good at art; able to make friends.

**How practitioners have built resilience to ensure risks faced are lessened or reduced:** Providing a mentor; provision of emotional management strategies; encouragement; building positive relationships; social education programmes; counselling

**How the child is viewed by practitioners involved**

**Education**

Education practitioners view Pupil D predominantly in terms of managing behaviour and relationships in school to prevent exclusion and to increase attainment. One practitioner recognizes that the child has:

Problems outside school and would be influenced by others to engage in the wrong kind of activities leading to trouble with the police, also her anger would cause problems amongst the community (Student Support Officer).

The Learning Mentor states that the child “struggles within the mainstream classroom environment and with boundaries.” Education practitioners appear to view the child as fairly typical of children that they work with due to “some
similarities around boundary setting and emotional management.” There is
general agreement that the child is “very typical in respect of attitude, confidence
and low self esteem” (Student Support Officer).

Health
Both health practitioners view the child as being very different from others
worked with in the school, the Counsellor states:

The pupil is a strong and opinionated individual portraying tough and somehow unapproachable personality…one desperately wanting to be a different person that is seen and portrayed.

The Nurse views the child’s behaviour as one that:

needs to manage in a way that is appropriate to her condition … The child needs to be understood. The child is at risk of anti-social behaviour and gang activity and thus needs activities to keep occupied. The child is one who is far more likely to be in trouble with the police and end up in a young offender’s institute. Support is available within the community as such pupils have such a negative impact on the community.

All practitioners focus on developing the child’s relationships with others through anger management and acquiring skills relating to conflict resolution. Only the Nurse makes reference to the child’s ADHD. There is no reference to the child’s hearing or learning difficulties.

How practitioners respond to such perceived risks
With regard to Pupil D, there is a general consensus amongst the practitioners that behaviour is the main risk for poor educational outcomes and it is here their focus lies. The child is offered a varied diet of support. From education, there is a focus on exploring ways with the child to better manage her emotions; building self esteem and confidence and developing social skills to improve relationships.
There is also an element of in-class support, small group work or working 1:1 to avoid distraction and disruption to self and others. From health, specific anger management sessions are given through counselling as well as through “discussing areas of the curriculum she likes and finding ways to have these areas nurtured – e.g. art” (School Counsellor).

**Effectiveness of interventions to reduce risks and build resilience**

The support offered to the pupil is primarily determined through the Statemented provision and thus the SENCO. The latter allocates the support available according to the individual need. Although there is psychological intervention, there is little dialogue between school and this service, only through parent.

The data collected from practitioners indicate interventions have been effective. Education practitioners refer to the child as now able to deal with her emotion far better:

The pupil can resolve conflicts much more positively than on previous occasions. The pupil is realizing how boundaries have an impact on those they come into contact with. The pupil is able to build up relationships with those they trust more confidently (Behavior Mentor).

Small steps have been achieved – this person now has the confidence to express concerns with certain members of staff and is attempting tasks that in the past she would not have done. Joining a group with other girls has helped with social skills. The pupil is more willing to negotiate with adults and peers this I feel has come around because of the encouragement I have given to her, listening to her concerns and the trust that school and home have built (Student Support Officer).

Of the two health practitioners involved, the Nurse states that that there has been little intervention undertaken other than “beyond liaison with CAMHS and with regard to medication.” However, the school counsellor stated that interventions
had been effective as evidence through “seeing a change in her ideas and mentality (personal constructs). The pupil now has more control over anger.” However, the Counsellor believes that:

there was no need to build resilience with this child as if anything she is over resilient....this is part of the problem.... My role was very much a nurturing one by helping her to understand that she could be loved and cared for without being judged or criticized. Offering the pupil an alternative view of who she is and how people could see her.

Pupil E

Brief background: Transition records showed that the pupil had been permanently excluded. Prior to this exclusion, the pupil had accessed support for those viewed as at risk of permanent exclusion and this support continued within the transferring primary school. The Educational Psychologist involved indicated, in a report written for the school, that the pupil wanted to change the behaviour that had led to permanent exclusion. Upon transition to the secondary school Pupil E was at school action plus for behavioural, emotional and social difficulties. It was reported that Pupil E is regarded as a bright pupil with specific learning difficulties. It was reported by the primary school that he was easily distractible and needed support to keep on task.

School summary: The school reported that the pupil has been very difficult to engage since transition. Educational psychology assessments indicated the pupil is of average ability. Upon transfer the pupil had a reading age of 6yrs and 10months and a spelling age of 7 years and 1 month. The pupil was reported to be reluctant to engage in work perceived to be too hard, gave short responses to questions posed and was relatively unwilling to talk about self. Transition reports about Pupil E indicated that he finds it hard to forge positive relationships with peers and staff. During Year 7 and 8, pastoral records indicated
that the pupil often presents as angry, stressed and tired. School reported that this was felt to impact negatively upon social and academic progress. Pastoral records indicated that the pupil appeared to lack strategies needed to avoid conflict and found it hard to control behaviour especially during unstructured times. The educational psychologist’s report noted the pupil could be threatening and aggressive towards other pupils, verbally abusive to staff and generally non compliant.

Records indicate that Pupil E found the transition from primary to secondary school hard, struggling to access the curriculum socially, emotionally and academically. The pupil received fixed term exclusions early in the first secondary term due to violent and aggressive behaviour and abuse to members of staff. Data held by the school indicates Pupil E’s attendance was poor from the beginning of Year 7. By the end of the first term the pupil had attended only 42% of the time. Documentation about the child indicates that the school recommended access to a high level of personalised support; expert behavioural intervention; literacy and numeracy support, anger management counselling, and a small school environment that caters specifically for pupils with behavioural, social and emotional difficulties. The pupil was thus placed in the school’s internal Pupil Support Unit. Records indicate that the pupil was initially difficult to engage due to non attendance and disaffection. Over the two year period Pupil Support records demonstrate that the pupil gradually developed a good relationship with staff. Parental relationships were also reported to be positive. It appeared that the pupil had also a strong advocate with regard to his grandfather. Over the course of time, pastoral records indicated that Pupil E was involved in significant difficulties within the neighbourhood and was identified by the police as ‘committing persistent nuisance.’ Neighbourhood incidents reported included stone throwing, disrupting football games, threats and intimidation, verbal and physical abuse, damage to council and private property.
Specific risks factors identified by practitioners: Anti social behaviour, low self esteem at risk of exclusion, behavioural difficulties; potential gang involvement and anti social involvement; lack of engagement with education; special educational needs; severe and persistent learning difficulties with regard to literacy.

Protective factors identified by practitioners: Family love and that able to make friendships; positive relationships with peers and adults; humbleness; trust in adults.

How practitioners have built resilience to ensure risks faced are lessened or reduced: Setting achievable goals; building on positive relationships; positive social integration; enforcing curfews and interactions with specific agencies. Cognitive Behavioural Therapy; pastoral support; basic skills support; anger management; self esteem work

How the child is viewed by practitioners involved

Educational practitioners see the child as being of poor educational outcomes due to having behavioural difficulties and being on the edge of criminality:

This student is involved in anti social behaviour in and around the communities he exists in – a very interesting character. He appears to be a very streetwise and displays himself to be a very irreverent person. He dominates peers and his presence is highly recognised within the community as negative (Behaviour Support Specialist).

The child is considered to be very difficult to engage in school, a poor attender, and one who is “often confrontational and anti authoritarian” (Behaviour Support Specialist). The Learning Mentor states:

The pupil is at risk of being permanently excluded from school. He can be very aggressive towards his peers.
The one social care practitioner involved suggests the child ‘misunderstands authority’ and the difficulty rests within the external social experience that the child has lived through. He further states that the child is very “vulnerable” and takes a societal perspective:

When interacting within his social networks, the pupil through learnt behaviour will misunderstand and challenge authority. He has not been taught generational respect, community cohesion or how to express emotional struggles (Youth Officer).

It is stated too, by this social care practitioner, that his behavior is “a by-product of his family life and upbringing.” The latter views the child within the context of neighbourhood and family and refers to the complex neighbourhood that the child lives in and the impact on the child and community of the, “higher percentages of poverty and unemployment.”

**How the practitioners respond to such perceived risks**

The educational practitioners’ understanding of the child all appear to be related to issues of behaviour, non attendance and low self esteem. Although the practitioners work within the SEN team at the school, there is no reference to the child’s specific learning difficulties (although as SENCO, I had ensured that this aspect was known to all practitioners through documentation held by the wider team) - the intervention is geared towards raising self esteem, behaviour management and to talk through ‘issues and problems’ - there is no actual intervention geared towards developing basic literacy and numeracy skills.

The way the two services deal with the child reflect the different conceptualisations they hold: The child is excluded from school as a punishment for aggression whereas social care professionals provide a cognitive therapy
course and anger management sessions. The social care practitioner also provides the opportunity for the pupil to take control of his own situation:

To help him understand his behaviour and the effect on others and the reason behind it...exploring realistic and achievable goals.

In terms of the child being representative of the locality there is a divergent response. Education practitioners see the child as “part of a culture that negates authority.” The Nurse views him as one of many with behavioural difficulties. However, the social care practitioner states:

He is fairly unique in his difficulty to learn and his present ability for his age. Socially: Unfortunately he is fairly typical of the Youth Offending Team client base. Poor parenting deprived neighbourhoods, professional criminal peers or family, low aspirations, etc. It seems common place. He represents a very small percentage of young people involved with the criminal justice system.

Effectiveness of interventions to reduce risks and build resilience
With regard to effectiveness of interventions utilised by practitioners there is consensus as to positive impact. There is general consensus that the pupil has developed a more positive outlook and has engaged better with all practitioners involved.

School focussed on building self esteem, developing behaviour and positive relationships. One practitioner commented on the child’s improved attendance and that his confidence had grown, “enabling the pupil to attempt work that in the past the pupil would have found impossible” (Student Support Officer). However, the efforts of the Behaviour Support Specialist to re-engage the child and work relating to his antisocial behaviour “to show him that other opportunities existed, different avenues to follow” was not entirely effective:
He seems defined in the role he finds himself in. He is highly influenced by holding a position of power among his peer group even though he is recognised as a negative force within society. He showed a glimpse of a positive character within.

The social care practitioner focussed on:

Helping him understand his emotional and mental needs through helping him understand his behaviour and its effect on others and the reason behind it. By exploring with him realistic and achievable goals. Enforcing curfews and interactions with specific agencies (YOT).

The latter reported:

We feel that as part of a multi-agency approach our input has been effective to a degree. The pupil has improved on his consequential thinking and has been conviction free for several months, through enforcement. He has also managed to complete a course with a specialist provider – this was also due to schools efforts to remove barriers by providing transport. He has returned to school for 2 half days per week and managed his behaviour with peers and staff much better.

Co-ordination of support appears to be effective and coherent due to statutory review requirements through the child’s statement of special educational need and through multi-agency involvement via the Area Casework Panel (a core agency representative body relating to Social care, Police, Housing, Youth Offending Team and Health).

Section B: Analysis of practitioners’ understanding of risks, resilience and building resilience

This section seeks to ascertain the similarities and differences between practitioners in their understanding and responses in terms of a) conception of
risks for poor educational outcomes; b) how practitioners understand i) the term resilience and factors that foster resilience and ii) how they build resilience.

a) Practitioner understandings of risks for poor educational outcomes

Practitioners working with the above children were asked as to their understanding of the risks the individual pupils that they worked with faced. Responses to the questionnaires indicated that the practitioners have good individual knowledge about each child but their understandings pertaining to risk are different. In general, their responses indicated that the practitioners tended to perceive risk factors for poor educational outcomes across the domains of the individual child, their family and their community.

Educational practitioners tended to focus on issues within the school such as on attainment, behaviour, attendance and the immediate school curriculum rather than on the wider community issues. Practitioners tended to see risks presented within the individual - at micro level - focusing on the child’s temperament, academic ability and intelligence, self esteem, relationships, etc, and considered mainly within the school environment.

Health practitioners focus on the individual but with emphasis on the biological aspects, for example, referring to ‘syndrome,’ ‘psychological disorder’ and ‘attachment issues.’ Their responses, while focused on the individual factors were different in that their references tended to be framed within pathology - e.g. health practitioners emphasised specific medical references such as Autistic Spectrum Disorder, ‘mild autism,’ ‘disorder’ and as having a ‘condition.’

Social care practitioners tended to focus on societal issues – the child’s vulnerability within the community and inability to ‘express emotions appropriately’ which impacted on their role in society. Emphasis on
neighbourhood issues was apparent, such as the level of crime and violence that
the child was exposed to. There was comment too on how society treats
vulnerable children and concern expressed as to that child’s acceptance in the
community. Social care practitioners tended to view children within the context of
the wider community - at macro level - and, although there were limited responses
from social care practitioners, there was some evidence of perception of risk from
a societal or cultural perspective, for example, the individual is at risk due to a
deprived neighbourhood, criminality of family and peers. There is almost an
‘apologist’ interpretation – the individual ‘misunderstands authority’ and ‘not
taught about generational respect or community cohesion or how to express
emotional struggles.’

There are few education practitioner references to family dysfunction and social
difficulties, such references tend lie in the domain of health and social care
practitioners. Maltreatment and child protection issues are referenced
predominantly by social care representatives and the School Nurse. Health and
social care practitioners appear to have a more holistic perspective as they focus
on social situations within the wider community. They tended to consider the long
term implication of the child’s learning needs i.e. “not being able to get a job in the
future” (Social Worker). They also tended to view the pupils within a community
child protection framework.

It is only with Pupil E that a child is seen more within the context of the wider
community and the impact of the deprived neighbourhood and low aspiration is
recognised by all practitioners involved. The reason for this is possibly the poor
attendance of the pupil in school and thus the difficulties the child has are seen in
this community context. Emotional and psychological risks are recognised by
education but their real focus was how the child performs, socially and
academically, within the school. The only real community focus was when there
were conversations with Community Police Officers as to the child’s anti social behaviour and gang involvement.

Indeed, the risks identified by all the practitioners tend to refer to psychological risk factors. There is little reference to actual impact of poverty, single parenting, unemployment violence within the community, poor housing except by social care representatives and only with specific reference to Case Study E.

**bi) Practitioner understanding of resilience and the factors that foster resilience**

Practitioners working with the case study children were asked as to their understanding of the term resilience and the factors that helped to foster resilience. Data from the questionnaire indicate a high degree of commonality across all professional groups in their general understanding of resilience. Practitioners all see it as the ability ‘to cope’ and the capacity to recover from adverse conditions:

- a person’s ability to cope with stressful, traumatic or negative situations without long term adverse effects to their mental health or general outlook on (Horticultural Therapist)

- The ability to cope with and bounce back from stressful situations (Form Tutor)

Practitioners across the key children’s services were able to identity factors considered important to foster resilience within pupils (see Appendix 12 and 13). Education practitioners appear to focus on the ability of the child to have positive relationships, being good at something and having a supportive school environment. However, one educational practitioner viewed one child as resilient stating: “resilient in the fact that he would take what he wants in order to exist. The child has no conscience” (Behaviour Support Specialist).
Health practitioners tended to focus on individual attributes such as intelligence, having an engaging personality, and the ability to develop positive relationships, as well as on external factors such as an extended peer group support. Excelling in something was considered important and positive self esteem. Health practitioners also refer to the importance of the familial dimension - aspects such as a ‘stable adult’ and ‘family love.’ Health practitioners are different from other practitioners in their reference to the importance of the child having opportunities to regain control and the importance of being responsible for own actions. One health practitioner felt that a child in question was over resilient - perhaps framing resilience as an emotive response rather than an innate quality.

Social care responses focus predominantly on the family, such as having a significant adult or family support, and on the wider community context with respect to positive interactions with agencies. There is also reference to the importance of development of individual attributes such as maturation and ability to listen. Social care practitioners reflected on the importance of the child understanding their own emotional and mental needs - building the child’s capacity to reframe adversities.

There are some clear overlaps between the practitioners regarding understanding of resilience. What is particularly common amongst all three groups is their general focus on the psychological aspects of resilience rather than the ecological aspects.

bii) Building resilience

Practitioners working with the case study children were asked as to their how they built resilience relating to the identified risk factors for poor educational outcomes that the individual pupils had. Resilience building was limited to involving the
individual and within a psychological framework only, as Table 14 below indicates.

Table 15 How practitioners build resilience with case study pupils

| Education practitioner responses | Building self esteem, using praise to develop self worth ensuring there was a significant adult developing pupil confidence encouraging the pupil to be good at something setting achievable targets |
| Health practitioner responses | Providing peer group support accessing talking therapies encouraging the pupil to regain control over an issue |
| Social Care practitioner responses | Listening to the child being a significant adult to the child working with the family to enhance understanding and relationships reinforcing positives through therapeutic measures |

There was a good deal of commonality with regard to strategies used by all practitioners. Use of praise and encouragement, having a named adult to go to or having a positive relationship with the child and regular dialogue/discussions were predominant across all practitioners. The importance of relationships and knowing the pupil well were clearly considered important in building resilience. The stability that school provided was highlighted and, apart from Pupil E (a serial non-attender to school) this is considered to be a major factor in building the resilience of the case study children. The psychological aspects of resilience were acknowledge across the practitioners, for example, the importance of counselling, building social skills, self esteem, relationship skills and confidence.

Educational practitioners emphasised building specific skills to enable the children to function within the context of the school environment. Their focus appears to be on individual target setting, reading, pastoral support, academic monitoring and social functioning within the school environment. As we saw earlier with
Pupil B, the main educational priority is for functioning in school and building relationships. The School Nurse sees her role in accessing additional specialist services or through specific interventions and the social worker takes a child protection stance to ensure the pupil is equipped with the skills to deal with sex, to increase stranger awareness and to ensure personal safety within the home. Social care workers appear to focus on enhancing the family involvement with the child and developing positive relationships, as well as helping the child to understand their own needs.

Section C: Coordination and coherence of provision
One of the overarching research questions was to ascertain if mechanisms were in place for coordination of provision based on shared understanding amongst practitioners and if the provision was coherent, coordinated, and effective. Practitioners were thus asked how their intervention was determined regarding case study children and results can be seen in Appendix 9.

Generally speaking, practitioner understanding of pupils at risk of poor educational outcomes and understanding of resilience are evident but no real overarching strategy is utilised to ensure the risks are minimised or addressed.

The variety of support is of interest. It is determined in the main by individual members of staff and by their own perception of what the issues are as opposed to being coordinated by external agencies coming together and planning together. The support appears to be of value as the pupils get emotional support leading to raised levels of self esteem and confidence. The pupils are often buffeted from difficulties they face on a day to day basis through the work of the practitioners involved.
In the main, the findings indicate that interventions were coordinated through consultation with the SENCo, through statutory LAC and statement reviews and through other formal assessment reviews. However, it is only with external agencies involved that long term strategies are put in place – specific therapy or emotional /educational programmes which are evidenced based strategies. Certainly at LAC case conferences for pupils A and B the support from social care is prescriptive and accountable.

The support for Pupil A centres primarily on ensuring stability within the home environment, that additional literacy sessions are made available through external reading schemes (not accessed by the pupil) and ensuring sporting interests are actively pursued given level of talent and desire. The horticultural involvement was put in place through liaison with social services case planning meetings to ensure emotional needs were addressed. The LAC inherent accountability structures ensure attendance and progress are reviewed termly.

The LAC case conferences and reviews for Pupil B have focussed on ensuring social and emotional needs are met through direct social worker involvement. Support also included therapeutic work accessed by social services in liaison with CAMHS.

The support offered to Pupil C is not as structured compared to other case study children as there is no statement for the child nor LAC status. There is dialogue with CAMHS but seemingly on an ad hoc basis. The support offered by school has been predominantly in class support, pastoral support and access to external specialist behaviour intervention. However, interestingly, the Behaviour Support Specialist states that work undertaken with the pupil should:
Ideally … be supported by contact with families and people working in schools. This was not possible here, except when meetings happened incidentally.

With regard to Pupil D support is primarily school based and involvement with CAMHS is, from a school point of view, manly indirect. Statutory meetings have not been attended by CAMHS and there is no significant dialogue between school and CAMHS.

With regard to Pupil E significant non attendance has hindered effective internal support. Offsite specialist provision is accessed with effective liaison and support mechanisms in place. There is effective multi-agency support. The reason for this lies in the difficulties that the pupil has within the community. As the Nurse states, for pupils like Pupil E at risk of anti social behaviour and gang related activity:

ACP involvement ensures all information is pulled together and agencies work together so there is good provision for such pupils. Support is available within the community as such pupils have a negative impact on the community. ‘[Whereas for Pupil B and C ]’Vulnerability has no social impact and thus little community support for such pupils.

With regard to Pupil E, criminality has determined provision and not statutory provision. As seen in Section 1 the involvement of the YOT has had a significant impact upon the pupil. This may be due to the fact that the pupil is far more accountable to the law enforcement procedures that are in place – e.g. non attendance equates to breach of court order and thus accountability structures determine, to an extent, outcomes.
There is evidence too, that, at times, the main determinant of intervention was often dependent on the individual working with the particular pupil. Thus, it may be argued that the constructs of individual practitioners determined intervention as opposed to a coherent and coordinated strategy.

The interventions implemented by health and social care practitioners appear to have a wider remit than that of educational practitioners - that of ensuring the child is being able to ‘function’ within society or purely for the benefit of the individual pupil such as ‘ensuring uniqueness is heard’ and for ‘social acceptance’.

With regard to effectiveness of interventions utilised by practitioners across the key children’s services, the impact is mixed and shows that practitioners working with the same child are often looking for different outcomes. Where there is consensus as to positive impact, success criteria was often different. For example, from an educational perspective the criterion for success was improved attendance whereas from a social care perspective the criterion for success for Pupil E lies in the child being ‘conviction free’.

Section D: Multi-agency working

Throughout the responses given in relation to the questionnaire, evidence emerged regarding certain frustrations with regard to practitioner relationships across the key children’s service providers. Not understanding how each other’s working environments operate was one cause of frustration. For example, the School Nurse stated: “I am not easily accessible in this school as I as in others.”

Lack of full multi-agency liaison, as demonstrated with Pupil C, caused intervention to be delayed and a coherent strategy to be impeded. The dialogue between the Form Tutor and Clinical Psychologist did not feed into a really
coherent strategy and proceedings relating to provision were consequently delayed. Further, minutes held by the school indicated from Psychiatry indicated that there was frustration with education in that the pupil has:

...gone through mainstream primary school without the extent of their difficulties having been fully recognized or understood.

A different interpretation of how a situation has been reached was another frustration, as well as the impact that government legislation had on intervention strategies:

Intervention was predominantly needs led but education regulations and attendance enforcement impact on service delivery as hard outcomes are expected for all pupils (Social Care Worker).

There was additional frustration with professional misconceptions. Practitioners’ own difficulties and professional ‘annoyance’ within own and respective organizations were a cause of frustrations, as the following questionnaire responses reveal:

Learning difficulties are not appropriately addressed and the child has thus missed out educationally... Social work is just sticking plasters – not getting to the root of the problem. I feel that her learning difficulties are not appropriately addressed and have thus missed out educationally (Social Worker).

School staff concentrates on the behaviour concern and not on the underlying issues. Some of the children are very vulnerable and unhappy but this is not dealt with by the school. The school is not as supportive as it could be (School Nurse).
The difficulties experienced by external colleagues and the inter relationships will be discussed in a later section, suffice to state here that the reality of day to day workings of a school perhaps appeared to cause divergent opinion of how things should be. Ironically, perhaps the above Nurse’s statement should be seen in the context that the support given to three out of the five cited pupils is through attending review meetings only, that the main role of the Nurse is one of ‘gatekeeper’, that the Nurse ‘does not really have much direct work with pupils’ and does ‘not have enough regularity of specific time in the school,’ due to extensive Child Protection commitments.

Conclusion

The practitioners involved with the case study children appear all to have had their own individual views about the child and tended to work with them in a way that suited themselves. The skills that the practitioners had tended to determine the interventions deployed. The practitioners all had clear working knowledge about the children but there was little real evidence to suggest that interventions were coordinated. How the practitioner viewed the child was the predisposing factor as to how they worked with them. It was noticed from the questionnaire responses that the educational practitioners tended to focus how the child presented within a school context only. This meant that in the main, the school was the focus at all times - how to get the child to combat underachievement, to solve relationship problems in school, acquire skills to access the curriculum, to manage anger to prevent exclusion from school.

There was little evidence to suggest the wider context of the child was considered. For example, with reference to one of the case study children, there is no mention of how to address the emotional needs of the child experiencing domestic violence or parental use of drugs and alcohol despite one of the practitioners having this
knowledge. Further, the impact of gang involvement for Pupil E was only really mentioned in connection to the adverse effect it was having on the community – it did not appear to be considered why the child was drawn to gangs - the attachment issues the child had with the mother or the fact that there was a familial link to the gang.

All of the pupils came from very deprived backgrounds but again this was not considered by the practitioners themselves. The lack of ambition or aspiration that Child D had was not addressed nor was the impact of bereavement on that child. However, the findings indicated that social care and health practitioners tended to take more of a holistic stance. There was some evidence to suggest that the practitioners across the key services differed in terms of outcomes expected. Education practitioners tended to focus on equipping pupils with skill to deal with difficulties experienced and thus emphasised the ability to ‘manage anger’, to ‘face up to problems in a mature and logical way’, and undertake ‘socialization programmes and use ‘emotional management strategies’ and to ‘be more socially interactive’. Strategies deployed by education practitioners to support the case study pupils to overcome risks faced socially related to building skills that are needed to ensure social progression within school to facilitate their learning. Thus counselling was offered to reduce anger which may lead to exclusion, developing skills to so that the pupil could ignore distractions such as ‘name calling’, exploring ‘strategies for managing emotions’ in order for learning to be effective. Strategies utilised had a focus on ensuring engagement purely within the educational setting.

Health practitioners tended to focus more on the pupil’s ability to understand own difficulties through analysis and focus on issues the individual faces and acting as a ‘gate keeper’ to more specialist services. For health practitioners, strategies
deployed to address social risks included self analysis and, similarly to social care practitioners, the long term consequences of current behaviour.

Social care practitioners support related to ensuring the pupils had understanding of their own mental health and emotional needs through helping them to understand their own behaviour and its effect on others, the reason behind it and talking through difficulties encountered - i.e. a more therapeutic intervention. Social care practitioners also focussed on developing skills relating to education outside the classroom – developing skills to ensure ‘road safety,’ and awareness of ‘danger stranger.’ They had the role too, of accessing additional services to address specific individual needs whereas school ‘liaise with external agencies’ to meet needs. Cognitive behaviour therapy was used by one social care practitioner as a way to change behaviour and thus impacting on the child’s actions for the future – a way of redressing patterns of anti social behaviour. Both health and social care practitioners focussed on building skills within the child for direct impact on society – to ensure behaviours are ‘socially acceptable’ and to ensure that the young person fits into society.

The practitioners appeared to work within their own frameworks and were at times critical of the other professions. It appears too, that statutory reviews are able to coordinate provision but the questionnaire revealed that there was really only a limited amount of coordination with respect to practitioner intervention. The questionnaire highlighted the specific ways professionals understood risks to poor educational outcomes; and indicated that there was understanding of risk and resilience, albeit limited. With regard to effectiveness of interventions utilised by practitioners across the key children’s services, the impact of interventions is mixed and shows that practitioners working with the same child are often looking for different outcomes.
The next stage of findings and discussion looks at the use of a risk and resilience framework amongst a group of professionals working with a particular child at the case study school. The child involved was reported to be a sporadic attendee to school and on the occasion when in school, presented as very stressed. The pupil was considered bright but documentation indicated that the child only engaged with one or two members of staff. It was reported that the child refused to attend lessons. The school felt that he preferred the security its internal support unit but that he had become very dependent upon this provision despite its emphasis on reintegration. It was reported too, that the child’s mother did not want this unit provision and urged the school to ensure mainstream provision. The school wanted this too. The educational psychologist involved reported that the child should access specialist ASD provision. They were clearly divergent opinions and no satisfactory outcome apparent. The differing professional perspectives about the child were evident - the school, school nurse, clinical psychologist and educational psychologist all had different views as to what the child needed. Multi-agency frustrations were surfacing and a resolution was clearly required for the benefit of the child and family. Thus, the researcher had the opportunity to utilise the risk and resilience framework.
Stage 3 Field trial of the risk and resilience framework

An overview

This section focuses on a field trial undertaken through a developmental multi-agency meeting within the case study school. It focuses on a Year 9 pupil highlighted at risk of poor educational outcomes and how professionals trialled the risk and resilience framework as a way to try to improve their outcomes. As a result of this meeting an agreed shared strategy was reached, demonstrating how a risk and resilience framework could be used for the future amongst the professionals from different agencies working within an educational context. Indirectly, it also served to illuminate some of the difficulties professionals experience when working together.

Context

I collated the following information from the documentation held by the school. The Year 9 pupil has a diagnosis for social and communication difficulties; he has a poor attendance record, low attainment levels and appears to be very dependent upon his mother. The pupil refuses to attend lessons and had become very attached to a Learning Support Unit within the case study school which was designed to cater for interim referrals with the emphasis on reintegration. The pupil’s mother was unhappy with this provision and wanted him in mainstream classes. The Educational Psychologist had previously formally assessed the pupil and concluded that the child required specialist Autistic Spectrum Disorder provision. This was disputed by the parent and by the school, who felt that mainstream provision with additional support was more appropriate.

A review was called by the Local Authority following an unsuccessful parental request for statutory assessment (due to divergent professional and parental
opinions) to establish educational provision and strategies to deal with the child’s complex needs. A common understanding of the child’s needs was seemingly required and thus an opportunity arose for me to ask professionals to consider looking at the child from a risk and resilience perspective.

The developmental multi-agency meeting

The aim of the meeting was to a) identify the specific needs of the child using a common assessment framework, in this case the risk and resilience framework; b) enable all relevant professionals to utilise a common language and thus have a better shared understanding of the child; and c) develop an intervention strategy that was shared by all professionals and the family working collaboratively together. I believed that sharing understanding and knowledge about the child from a more holistic view would possibly be a more effective way of working with and supporting the child.

Professionals from across the key children’s services, involved with the child, were asked by me individually to consider the child from a different perspective in order to ascertain a more systematic assessment of the child in a common way. It was thus agreed prior to the meeting that the invitees would view the child in terms of risk, resilience and protective factors. A multi-agency meeting was thus held, and, as chair of the meeting, I outlined the aim of establishing an agreed strategy to improve the child’s educational outcomes. This was to be achieved by looking at the risks factors, how the presenting risks could be reduced, identifying protective factors and building resilience.

Attendees at this multi-agency review were: the school’s Special Needs Coordinator (the Researcher), the pupil’s designated Teaching Assistant, (School Nurse - report only), the Student Support Officer, the Educational Psychologist,
the Clinical Psychologist, the Psychiatrist, Mother and Parent Partner Worker. (NB: Although the Parent Partnership Worker is employed by Education their predominant focus in this case was on the social perspective of the child and that of the family).

At the meeting, I asked those present to consider a) the factors in this child’s life that place him at risk of poor educational outcomes; b) what is enabling him to do well (protective factors); c) what are the common concerns and priorities that we as professionals and the parent working together have and d) what will our shared strategy be.

a) **Risk factors for poor educational outcomes**

With regard to factors that placed the child at risk of poor educational outcomes, the responses stemming from discussion were varied and are outlined below:

**Education**

Education professionals focused on the child’s poor attendance to school which was considered to be due to three main factors; not wanting to be separated from his mother, being frightened and anxious about school and the recent move to a brand new build. The child did not like change and thus the recent move to the new build significantly disrupted his pattern of attendance which was poor anyway.

Education professionals reported that the child had a high level of anxiety as exemplified by the fact he would only engage only with a few members of staff; his point blank refusal to attend lessons without support and his general demeanor, which was one of nervousness. He had developed no peer friendships and thus had no friends to support him within class or within the general school environment. Education professionals also reported that when the child
felt anxious, he become verbally aggressive and defiant. Although the pupil related to a few members of staff, he nonetheless did so sporadically and always on his own terms. This behavior, due to his nervousness, was considered to be disguised through his presentation of being in full control of his emotions and which often led him getting into further difficulties.

Health

Health professionals focused on the child’s non attendance and non engagement in lessons and these were attributed to his social and communication difficulties. The Clinical Psychologist reiterated the difficulty he had due to his Autistic Spectrum diagnosis, as well as his negative experience of education within the secondary sector. It was specified that the child did indeed have high levels of stress and anxiety. It was further revealed that the child disliked noise. The Psychiatrist involved reported that the child had an obsession with his body and clothes; further, that his attendance issues could be attributed to a detachment disorder i.e. not wanting to be separated from his mother.

Social care

The parent and parent partnership worker offered further verification of the child’s specific difficulties. The parent and parent partnership worker added additional information to those present including the child’s persistent lack of sleep and poor diet. The difficulties the child faced with regard to the social demands of school that he could not deal with were highlighted. The parent partnership worker and parent verified that the child was dependent upon mother; had a high stress level and was very anxious; the parent indicated that the child did not deal well with crowds, people or noise. Further, if his siblings upset him he would subsequently refuse to come to school as he wanted to stay at home and feel safe. Information was shared with regard to the fact that the child only had a couple of friends, both of whom had significant learning difficulties. It was
conjectured that the child could not manage full time education due to the above reasons stated. The parent alluded to family and wider community issues of substance abuse and criminality.

b) Protective factors identified

The attendees at the meeting were asked to consider what is enabling him to do well, and the responses are outlined below.

**Education**

The professionals focused on what the child was good at in school such as being able to form relationships with certain staff, the good sense of humour the child had and certain skills that he had, such as being good at ICT and art. It was noted that the parent and child had a good relationship.

**Health**

The Nurse reported that the child was in general good health and engaged in conversation when appropriate. It was felt that the child responded well to adults that cared for him. It was viewed that the child liked routine and structure due to his ASD. It was reported that at primary school the child engaged in and enjoyed learning.

**Social care**

The child was reported to have good relationships with adults and siblings. It was stated that he enjoyed learning and playing computer games. The child was able to help around the house and engage in family activities. It was noted that the child was able to make friendships especially with younger children.
c) Risk and protective factors surfacing

From this initial discussion it was evident that asking those present to think of the child around risk and protective factors enabled a base line understanding of the child upon which an agreed strategy could be built. The meeting had appeared to generate a greater understanding of the issues surrounding the child and how protective factors could be enhance or developed to mitigate the risks identified through a shared strategy based on a common understanding of needs. The discussion enabled those present to look at the child in far more holistic way compared to previous meetings which tended to focus on the child’s educational provision. Information pertaining to the child and family were surfaced that had not previously been considered or acknowledged at previous case conferences. Thus, a more coherent understanding emerged based on a shared language and common evidence base (Croom and Procter, 2005).

From the risk and protective factors that surfaced from discussion, I was later able to divide them into three main categories:

**Risk factors**

**Individual:** The child’s low esteem, poor communication skills, difficult temperament; attachment issues and academic failure; lack of sleep and anxiety issues.

**Interpersonal and social:** Poor and inconsistent discipline, family conflict, specific sibling conflict and aspects of criminality within the home environment.

**Environmental:** The significant socio economic disadvantage that the child came from and experienced. Community criminality and substance abuse.
**Protective factors**

**Individual:** The child’s identified talent in ICT and art; his ability to engage with a trusted adult; his humour and cognitive ability.

**Interpersonal and social:** The child’s stable and caring home environment; positive response to rewards, the warm and significant relationship that he had with his mother; having an effective parental advocate, a family with secure employment; ability to make and maintain friendships and the child’s strong sense of family belonging.

**Environmental:** The family’s access to health services and leisure facilities and secure employment for the family adults.

This above exercise allowed all involved with the child to share views and knowledge about him shaped by the risk and resilience framework. Unlike other previously held meetings, the framework enabled those present to view the child in a way that was different from those meetings held. Although I can only give anecdotal information, previous meetings had tended to focus on given problems emerging at a given time, such as behavioural concerns or non-attendance to school. Prior to this meeting, there was some discord between education, health and social care as to the needs of the child. Previous meetings had not resolved divergent professional differences. Professionals had tended to see the child from their own perspective. Reports from school indicated that attendance and attainment were the key cause for concern and that provision through the internal Pupil Support Unit was appropriate in meeting the child’s needs. The Psychiatrist and Psychologist tended to focus on the ASD aspects of the child’s difficulties and wanted specialist support for the child. Parent Partnership supported the parental request that the child should be in mainstream lessons and not be catered for within the school’s Unit. Thus, the risk and resilience framework brought about
something different. It seemingly unified professionals present which had not previously been attainable. This meeting was different too in that a common language was used and one that appeared to be understood by all present. Previously, there had been no real holistic view of the child.

The accrued information from the meeting appeared to allow professionals to have a far greater insight as to the presenting difficulties. During the proceedings, some of the issues that the parent representative spoke about were unknown to school and, indeed, to the other professionals present. For example, the sharing of information brought up an issue of friendship – the child had a very small circle of friends – one with severe learning difficulties, one with social difficulties and two brothers who had just lost their mother through suicide, and who also had significant learning difficulties. The Psychiatrist viewed such friendships as those who present no danger or challenge to him intellectually, emotionally or socially. This was a perspective that the educational representatives had not considered. It also became apparent that the child rarely left the house and the dependence upon his mother was perhaps more of an attachment disorder. This was an aspect that had not previously come to light. It became apparent too, that sibling difficulties had a negative effect on him and if a sibling upset the child in the morning through ‘bullying’ then he would subsequently refuse to go to school. Such information was only forthcoming because the risk and resilience framework allowed professionals to consider the child across different domains; in the context of the home, school and the wider community. Previously, meetings held concentrated just on school related issues and not on the wider factors.

d) Common concerns and priorities of professionals and parent

Having discussed the child from the risk and protective factors perspective, we then went on to discuss how the presenting risks could be reduced and how to foster the protective factors and build resilience. We thus discussed a way forward
as to how to reduce risks presented such as how to improve attendance, build
confidence, raise self esteem and how to reengage him with the curriculum; how
to build on protective factors and develop resilience, such as using his talents to
reengage him in education and how his positive relationships with his mother and
some teachers could be developed; and how to develop social competencies and
networks to prevent continued isolation from his peers and lessen the attachment
issues he had with his mother. This included aspects of making school a more
attractive option as well as providing specific interventions to cater for his special
needs.

The shared strategy required needed to build on the support available around the
family and community as well as providing specialist services to address his
anxiety, stress and particular ASD needs such as presenting obsessions with body
image, food and clothes.

Those present at the meeting all concurred that the pupil needed to be surrounded
by a number of adults who could understand him and provide intensive support,
with a long term view for the child to access the whole curriculum. The parent
agreed that the child would be happier with the idea of having adults around him
who would not leave him alone in lessons, etc.

At the meeting, it was recognised that the pupil had a clear attachment to his
mother; however, it was also recognized by all incumbents that home was a far
more an attractive proposition than school. The Education Psychologist advised
the staff to make the school seem more attractive, i.e. with structures and routines
in place to make it feel like a safe place for the pupil. The Psychiatrist explained
that this was because the child felt unsafe, insecure and anxious in school and that
school needed to address such issues through lessening his perception of
uncertainty through the provision of a stable, quiet and secure environment. It
was felt appropriate that a bespoke system of rewards and targets should be built into the provision outlined for the pupil and that the school would focus on building positive relationships with him, both adult and peer. The Psychiatrist suggested this be undertaken with a social focus rather than academic one.

It was agreed too, that the newly appointed teaching assistant for the pupil needed time to engage with him through working with one of the members of staff that could already engage with the pupil and in whom he trusted. It was acknowledged that this process would take time and involved significant collaboration between the teaching assistant and the member of staff that currently worked with him.

It was recognised by those present at the meeting that the school needed to start again with supporting the child to access the general school environment. The Educational Psychologist advised for the need to backtrack to the foundations for the child, for example, take him to the empty classroom and introduce him to the teacher, possibly go over the lesson content, etc, in order to prepare him with the idea of going to a lesson. The school were advised by the Psychiatrist and Clinical Psychologist to link with the local specialist ASD School to seek advice and guidance given their success with high functioning ASD children.

At the meeting, it was felt that home issues needed to be addressed, especially with regard to possible perceived attachment the child had with his mother. This relationship and the obsession with clothes and body issues was an area of focus for the Psychiatrist in order to address these aspects. A shared strategy of reducing risks, build protective factors and resilience began to emerge which focused on:

**Reducing risks:**
- raising self esteem
• improving attendance
• ensure engagement with school and learning
• developing positive peer and adult relationships

Developing protective factors and building resilience:
• focusing on strengths such as humour, ICT and art
• developing a more balanced relationship with his mother and siblings
• reducing the child’s dependence upon and attachment to the mother
• addressing the child’s ASD and, in particular, the needs specific to the pupil within the home and school environment.
• building on the child’s ability to have positive relationships with peers and adults
• developing the child’s cognitive ability relating to learning

A shared strategy
It was through the enhanced joint understanding of the child, possibly brought about through the use of the risk and resilience framework that a professional consensus was reached, a strategy agreed and, thereafter, implemented. Prior meetings had tended to be dominated by professional cultures, focusing on mainstream or specialist provision. There had been discrepancy as to the child’s educational needs. However, one should not preclude other possible reasons for the success of the meeting. The use of the risk and resilience framework in the field trial may have been successful for a number of reasons, e.g. sensitive, structured and active chairing; a well maintained and focussed discussion; participative and ensuring all views were valued; the venue where the case conference took place; and that the ‘rules’ of the meeting (an implicit side effect of having a risk and resilience framework) were that everyone would listen to the perspectives of each other in order to secure an full understanding of the child
which had not previously been established. Ensuring that the key people involved with the child were able to attend the meeting was also an important factor to its success.

This aside, looking at the child from a neutral framework allowed professionals to see and understand the child from a holistic perspective. Looking at risk and protective factors certainly elicited additional informational that the professionals involved with the child prior to the meeting had not known, thus allowing for a more appropriate strategy to improve outcomes both for the child and the family. Ultimately, the agreed actions were linked to building resilience based on the risk factors and protective identified.

**Agreed actions**

The following actions stemming from the meeting were thus agreed:

- Psychology and Psychiatry staff commitment to provide ASD training for all school staff and specific training for the Teaching Assistant employed to work with the pupil (dates were subsequently agreed)
- Attendance rewards to be used to encourage the pupil to come in to school. The school and family were to work closer together
- Regular use of praise and rewards to raise self esteem through focussing on the child’s strengths and talents such as ICT and Art
- The Psychiatry team were to focus on supporting the home in meeting the needs presented by the pupil
- School to provide; a highly structured environment for the pupil and implementation of a strict routine with visual prompts in to create a safe and secure environment; 1:1 teaching assistant support; a shorter school day; a reduced personalised timetable building on subjects enjoyed by the pupil and delivered by staff who were able to understand his needs
How this relates to building resilience

Training provided regarding ASD would help the school to cater more effectively for the child’s needs and thus enable staff to develop systems, strategies and support to meet the specific needs presented. This would thus give the child a better environment in which to learn and encourage attendance to school on a regular basis. Encouraging a joint approach with the child’s family to improve attendance would enhance learning and thus improve educational outcomes. It was agreed that the child would not be able to cope with a full time school placement and thus a part time placement was agreed with supplementary work to be undertaken at home using a laptop to enhance interest in ICT and to work with his mother in an educational way. This would enable the child to catch up on work that he had fallen behind on due to intermittent attendance. The identification of subjects enjoyed by the child was to be the lever to encourage the child back into education – building on individual interest, cognitive ability and enjoyment to enhance learning. Thus, from an education perspective, rather than focussing on the issue of non attendance, for example, a more constructive strategy was brought about. The school would support the parent through regular contact such as handing the child over to a trusted adult each morning at the school to build confidence. From health, the difficulties experienced by the school and parent were to be addressed to support the child. In addition, the parent was to be directly supported by the psychiatric team through working with the family to increase their knowledge and understanding of the child and by advising on strategies to deal with difficulties experience by the family as a whole. The parent and parent partnership worker agreed to support the strategies and communicate regularly with professionals involved. The package of care was a combination of across service universal, targeted and specific provision.
One final, albeit incidental, outcome of the meeting was an agreement that school and the psychology service work closer together to re-present documentation for statutory assessment and agreed advice.

**Conclusion**

The risk and resilience framework appeared to be utilised successfully to establish a better understanding of the child’s needs, to implement a shared strategy and thus, potentially, improve educational outcomes. Identifying specific risks, reducing those risks, identifying protective factors to build resilience appeared to allow the professionals and family to understand the child better through a shared conceptualisation. The discussions based on risk and protective factors did seem to surface a more mutual understanding of the child.

Although the field trial was limited to this one particular case, the framework did seem to allow for a shared language to be used. Further, it appeared to improve the professionals’ capacity in identifying the way forward in terms of resources and services. This was achieved through a plan of effective intervention which responded to the child’s presenting risks and enhanced the protective factors, thus building resilience. The framework appeared to enable those present to understand the child better. Rather than just focusing on the child’s problem of, for example, ASD, the framework enabled a holistic understanding as we looked at all the factors that contributed a risk to poor educational outcomes and the protective factors that we could use to build resilience and better outcomes for the future.

The meeting served to identify the factors that indicated that the pupil was at risk of poor educational outcomes as well as the protective factors or strengths that could buffer the child and protect against poor educational outcomes. The initial outcomes of the meeting were seemingly effective. Identifying the factors that placed the pupil at risk of poor educational outcomes was beneficial as it ensured
professionals had a far clearer insight into the specific needs of the pupil concerned as well as an informed overview as to what enabled the pupil to do well. There appeared to be a shared understanding and strategy for reducing risks and promoting resilience amongst the professionals involved with the pupil, including the parent. Further, there stemmed a plan of action that was understood, shared and owned by all professionals and the family of the particular child. This had not happened at previous meetings.

The information that surfaced from the meeting gave education professionals a clearer understanding as to difficulties experienced by the child both at school and in the home environment, as well as an insight into the strategies that needed to be in place for future progression. Information about home life and sibling difficulties had not emerged at previous meetings, nor had information been given about his obsessions with body and food. It was not known from previous meetings held that the child only had a few friends and was socially isolated. The relationship with siblings had not been discussed nor the negative impact that this had on the child.

Both the Psychiatrist and Psychologist appeared to emerge from the meeting with a more holistic view as to the needs of the pupil especially with regards to the home situation. They had not previously considered the lack of neither family understanding of ASD nor the degree to which the child’s ASD impacted on home life. Further, the meeting surfaced the possible detachment disorder that the child had with the mother and one that warranted further investigation.

The Parent Partnership Worker also felt that the parent had a better understanding of the child’s difficulties arising from this meeting and clearer strategies to overcome them.
Most importantly, by establishing common concerns and priorities, an appropriate and coordinated response became achievable, with all professionals appearing to understand and agree their specific role for a common outcome.

The results of this multi-agency development meeting indicated some of the benefits of using a risk and resilience framework. What the risk and resilience framework provided was an effective basis on which to secure a commonality of understanding and, thereafter, facilitated a shared strategy in response to meeting the needs of the child. It appeared that the shared cumulative knowledge stemming from the meeting through using the risk and resilience framework enabled a better understanding of the pupil’s specific needs and thus increased the capacity of professionals to meet those needs more effectively than previously was the case.

Nonetheless, I recognise that the results stemming from this field trial should be interpreted with caution given that the risk and resilience framework was used in one example only and that a different framework could have achieve similar result.

The developmental multi-agency meeting also served to highlight some of organisational and cultural difficulties associated with multi-agency collaboration. Subsequent to the meeting, it became clear that issues of communication and understanding of each other’s roles were areas that still needed to be progressed. Frustrations and differences of professional opinions still needed to be worked through.

Professionals across the key children’s services involved in this case tended to blame each other when things went wrong. For example, a miscommunication between the Clinical Psychologist and a school representative resulted in a rather fractious email that questioned professional competence. Likewise, the statement
made by the Psychiatrist that they did not feel it was their responsibility to advise school with regard to obsessional behaviours presented at home was an area that needed further resolution. Further, the appropriateness of an ASD specialist unit for the pupil continued to lead to divergence of professional opinion. Such difficulties were perhaps representational of the deep rooted cultural and organisational difficulties of multi-agency working.
Stage 4: Research and empirical review of literature

An overview

Locating findings within the review of literature is seen later towards the end of the thesis. However, the literature also formed part of my empirical work as it allowed me to establish a framework that I could compare later research participant responses to. The information stemming from the review of literature with regard to multi-agency collaboration, risk, protective and resilience factors provided a context, a set of ideas and concepts that I was able utilise to make sense of the data. Thus this section briefly brings that information together.

Multi-agency work

The findings indicated that there were barriers relating to different pay and conditions; roles and responsibilities; competing priorities; difficulties due to bureaucracy and professional and cultural difficulties. There was little evidence within the data as to facilitating factors other than references made to improving communication and understanding of each other’s roles and responsibilities. There was no evidence of commitment; commonality of aims and objectives, leadership and sharing of resources within the research undertaken (see Appendix 15).

The evidence collated from the research with regard multi-agency facilitators and barriers seemingly parallel that stemming from the review of literature. For example, the different conceptualisations professionals have and the lack of a common language, etc, appeared to be significant cultural barriers to effective multi-agency working. There was evidence too, of particular organisational difficulties, but as previously acknowledged, there is little one can do about this
other than through policy and appropriate management systems. The cultural and organisational difficulties were a theme that emerged through the interviews, questionnaires and the field trial.

**Risk, protective factors and resilience**

The findings indicate that professionals and practitioners viewed risk at micro, meso and macro level (Corcoran and Casebolt, 2004). Professionals across the children services professionals identified micro level of risks such as temperament, learning difficulties; meso factors such as community violence and gang related activity; and macro factors such as poverty and unemployment (Appendix 16).

The findings indicated identification of a wide variety of risk factors for poor outcomes. Risk factors identified by at least two professionals at interview and / or through the questionnaire compared to those highlighted consistently over the last decade or so by researchers (such as Masten and Coatsworth 1998, Fraser 1997) may be seen in the table below. The factors identified previously in Chapter 2 correlated closely to those found in the research but there were some differences. The differences may be explained in part due to their sensitive and confidential nature

**Table 16  Commonly identified risk factors from the review of literature compared to the research findings**

<table>
<thead>
<tr>
<th>Same risk factors from the review of literature compared to research evidence</th>
<th>Non comparable risk factors from the review of literature compared to research evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refugee / asylum seeking status</td>
<td>Principle carer overwhelmed</td>
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<tr>
<td>Domestic violence</td>
<td>Early sexual experience</td>
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<tr>
<td>Poverty</td>
<td>Serious accident</td>
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<tr>
<td>Poor nutrition / hunger</td>
<td>Discrimination</td>
</tr>
<tr>
<td>Poor educational attainment</td>
<td>Physical disability</td>
</tr>
<tr>
<td>Familial illiteracy / Educational failure</td>
<td>Temporary/ chronic/acute physical ill health</td>
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<tr>
<td>Minority ethnic families</td>
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</tbody>
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<table>
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<tr>
<th>Looked After Status</th>
<th>Physical health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Educational Needs</td>
<td>High attendance at A&amp;E</td>
</tr>
<tr>
<td>Parental criminality</td>
<td>Bedwetting / soiling</td>
</tr>
<tr>
<td>Poor education</td>
<td>Teenage mothers</td>
</tr>
<tr>
<td>Marital discord</td>
<td>Low warmth / high criticism household</td>
</tr>
<tr>
<td>Family dysfunction</td>
<td>Maternal psychiatric disorder</td>
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<tr>
<td>Foster placement</td>
<td>Overt discipline</td>
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<tr>
<td>Large families</td>
<td>Safe housing</td>
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<tr>
<td>A move to a new area / neighbourhood/mobility</td>
<td>Homelessness</td>
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<tr>
<td>Gender specific related risks</td>
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<tr>
<td>Mental / Emotional Health</td>
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<tr>
<td>Specific emotional or conduct disorder</td>
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<tr>
<td>Temporary/ chronic/acute mental ill health</td>
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<tr>
<td>Poor social skills</td>
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<tr>
<td>Low self esteem</td>
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<tr>
<td>Stress</td>
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<td>Depression</td>
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<td>Suicide attempt / self harm</td>
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<td>Antisocial behaviour</td>
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<td>Family dysfunction</td>
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<td>Maltreatment</td>
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<td>Poor parental relationship</td>
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<tr>
<td>Poor parental discipline</td>
<td></td>
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<tr>
<td>Substance / Alcohol misuse</td>
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<tr>
<td>Trauma / catastrophic life events</td>
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<tr>
<td>Death of close relative</td>
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<tr>
<td>Child ill treated / neglected /abused by</td>
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<td>parent/sibling/relative/</td>
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<tr>
<td>Bullying</td>
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<td>Domestic violence</td>
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<td>Community violence</td>
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<td>High crime within community</td>
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<td>Poverty</td>
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<td>Overcrowding</td>
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<td>Poor accommodation</td>
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<td>Socially isolated</td>
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<td>Single parenthood</td>
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<td>Unemployment</td>
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Table 17 below indicates common protective factors from the literature review undertaken compared to those identified through the field research undertaken. The factors identified in the Chapter 2 were compared to those identified by at least two professionals at interview and/or through the questionnaires.

Table 17: Common protective factors from the review of literature (e.g. Stein, 2005; Williams, 2001; Masten and Coatsworth, 1998; Fraser, 1997.) compared to factors identified by at least two professionals within the field research undertaken

<table>
<thead>
<tr>
<th>Common protective factors from the review of literature compared to field research undertaken</th>
<th>Uncommon protective factors from the review of literature compared to field research undertaken</th>
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</thead>
<tbody>
<tr>
<td>Positive self esteem</td>
<td>Resistance to oppression</td>
</tr>
<tr>
<td>High self regard</td>
<td>Racial / ethnic socialization</td>
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<tr>
<td>High cognitive ability</td>
<td>Creative problem-solving skills</td>
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<tr>
<td>Talent</td>
<td>Experience with self-mastery</td>
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<tr>
<td>Secure base</td>
<td>Faith</td>
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<tr>
<td>Humour</td>
<td>Family resilience</td>
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<tr>
<td>Self efficacy</td>
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<tr>
<td>Sense of belonging</td>
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<tr>
<td>Friendship</td>
<td></td>
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<tr>
<td>Positive attachment to a significant adult</td>
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<tr>
<td>Social support</td>
<td></td>
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<tr>
<td>Warm, caring relationship</td>
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<tr>
<td>Accomplishment / positive experiences</td>
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<tr>
<td>Academic attainment</td>
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<tr>
<td>Good health</td>
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<tr>
<td>Effective parental advocates</td>
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<td>Good education</td>
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<tr>
<td>Easy temperament</td>
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<tr>
<td>Emotional literacy</td>
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<td>Family cohesion</td>
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<td>Competent parental skills</td>
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<td>Positive reinforcement</td>
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<td>Effective schooling</td>
<td></td>
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<td>Adequate resources within health services – nutrition and health care</td>
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<tr>
<td>Employment</td>
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<td>Sense of identity</td>
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<td>Personal responsibility and autonomy</td>
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<td>Social competence; an ability to tolerate frustration and manage emotions; a feeling of personal control over one’s life and self-confidence</td>
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<td>Optimistic outlook</td>
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<td>Persistence in the face of failure</td>
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<td>An ability to seek out support</td>
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The review of literature highlighted common ways of reducing risk and building resilience i.e. through a) direct intervention b) reducing stressors c) increasing services and resources to vulnerable communities and d) mobilizing protective processes (Fraser 2004; Smokowski, 1998 and Masten, 1994). The findings arising from the analysis of data indicated that professionals with hands on involvement with children tended to use predominantly direct intervention, compared to the use of reducing stressors, increasing services and resources, and mobilizing protective processes as demonstrated amongst professionals with management responsibilities or in positions of management (see Appendix 17).

**Conclusion**

There can be little doubt as to the willingness of the professionals and practitioners to be involved in improving educational outcomes for the children involved, but the lack of any real coherent and cohesive planning and implementation of service provision clearly warrants further consideration. The study indicates that the different conceptual understanding relating to children held by professionals across the key children’s services, could lead to inefficient use of resources, and poorly coordinated and ineffective interventions. The different way professionals talk about and understand children became evident in the data analysis. The use of jargon and technical language was evident
as were the different conceptualisations. Education tends to focus on the school and attainment, health on pathology and social care has a clear bent towards family and societal issues.

Lastly, the study explored the use of a common framework for practitioners to be able to understand children and coordinate strategies and considered if the use of the risk and resilience framework could be helpful. The use of the framework, outlined in the previous section, indicated a degree of efficacy and appeared to allow professionals to agree a strategy that had previously proved difficult to achieve. The framework appeared to allow the professionals involved to see more of, and understand more fully, the child and the notion of risk appeared to be a useful way of allowing professionals to identify different types of risks as it was not exclusive or limiting. However, the cultural and organisational difficulties of multi-agency working were nonetheless still apparent. The conclusions to the study are discussed in the next chapter.
Chapter 5: Conclusion and Recommendations

An overview

This final chapter revisits and reflects on the purpose of the research and its findings. It considers the advancement made to the research field relating to multi-agency collaboration and professional conceptualisation. The chapter revisits and answers in summary form the research questions and gives the conclusions of the research. The contributions to scholarly knowledge, limitations to the research and implications for policy and practice are thereafter presented.

Thesis: aims and research questions

This study focuses on multi-agency collaboration within the key children’s services of education, health and social care. The aim of the study is to establish:

1. What understandings of risks for poor educational outcomes do professionals from different backgrounds, but working with the same children, have?

2. How congruent with each other are those different understandings?

3. How congruent are they with understandings of risk in the research literature?

4. How do these professional understandings shape the interventions with children that the different professionals propose, and what are the implications for the possibility of co-ordinated and effective interventions?

5. Is the risk and resilience framework a viable one to utilise by professionals from across the key children’s services, in order to develop a shared understanding of the child and thus ensure coordinated and effective interventions?
Research findings

1. What understandings of risks for poor educational outcomes do professionals from different backgrounds, but working with the same children, have?

The findings indicated that professionals from across the key children’s services were able to cite a range of risks factors for poor educational outcomes. For example, they identified a variety of factors including Looked After status, poor academic engagement, non attendance to school, the impact of family on the individual child, lack of a caring and nurturing family environment. Professionals indicated that risks came from different sources - from within the child such as self esteem, communication skills, temperament and cognitive ability; within the family such as family and sibling relationships, and within the community - socio economic status, level of employment and community stability.

Professionals with day to day contact with the case study pupils or who worked within the case study school indicated a good degree of knowledge of the children and the environment in which they worked. With the exception of the two Headteachers interviewed, who operated within the immediate environment of the case study school, understanding of those that held posts of significant management responsibility of respective children’s services tended to be more theoretically based in comparison to those who worked at regular front-line level.

At management level, there was a degree of unified professional conceptualisation. It was clear from the interviews, for example, that the Clinical Psychologist used a pathologising approach and the Horticulturist a psychotherapy framework. Similarly, the Educational Psychologist utilised a diagnostic model to construct a professional conceptualisation. The management representatives from social care gave answers steeped in social work policy - referring repeatedly to guidelines in the law.
At both fieldwork and management level, different professional conceptualisations were evident. For example, the Counsellor used a psycho-analytical approach to seek understanding of a child; the teachers’ approach related to how best manage the behaviour of the child; and the social cares’ approach was to seek understanding through looking at external factors causing distress to the child.

Understanding of risk was limited but only to the extent in that professionals did not demonstrate an understanding of risk from a comprehensive perspective - they did not break understanding of risk into psychological, biological, social, spiritual, environmental, physical, emotional, environmental, individual, family, community or culture / ethnic constructs (Bronfenbrenner, 1989) nor did they indicate their understanding of their respective inter-relationships. The professionals tended to view risk within their own narrow perspective. It was limited to the specific environment in which they worked - they all had a restricted focus based on a limited perspective. Educational professionals tended to view risks predominantly within the child whereas health and social care professionals tended to focus on factors pertaining to the family and wider community.

All professionals demonstrated the clear parameters within which their concepts were formed; educationalists focused on academic and attainment related issues, health on pathology and social care on family and society. The research further indicated that professionals within the same organisation tended to use their own knowledge and ideas to inform interventions - there was little real evidence of co-ordinated intervention based on shared conceptualisation.
2. How congruent with each other are those different understandings?

Professionals from different backgrounds, working with the same children had a degree of commonality in their understanding of risks for poor educational outcomes. All cited key risk factors with regard to poor educational outcomes, however, the different professionals groups did vary in their focus. Educational professionals tended to focus on the risk factors pertaining to a) individual characteristics such as a child’s temperament, behaviour and intelligence and b) influence of the family. Their understanding tended to be primarily focused within the immediate environment in which they operated.

Although the two Headteachers and Educational Psychologist made reference to the risk factors within the specific community in which they worked, the practitioners mainly emphasised the context of the actual school and the pupils were predominantly seen purely within that context. There was an emphasis too on poor educational engagement as a risk factor and this was seen as stemming from within the family and the community setting. The wider problem of anti social behaviour was acknowledged but only really in the context of the adverse effect it had on pupil academic performance or behaviour within the school itself. Although educational professionals understood the difficulties that were within the community, they were seen as risks to poor educational outcomes because of their impact on the child within the school environment and not because of community issues per se.

With reference to the wider community or society, some educational professionals referred to unemployment and the resulting expectation of failure as significant risks factor for poor educational outcomes - it was a view particularly held by those working specifically with parents or actually living themselves within the community itself.
Health professionals primarily focused on the individual biological and psychological factors that determined poor educational outcomes. Health professionals tended to see the family from a genetic and early development/nurturing perspective. They more frequently referred to the family context and referenced the genetic or congenital aspects within the child and the resulting psychological stress as risk factors for poor educational outcomes. The health focus was wider in that representatives referred to the level of significant poverty within the community but only in that it impacted on general inequalities of health provision, referencing the impact that deprivation had on child diet, nutrition and development, and subsequently on education. Health professionals made reference to the wider difficulties that were associated with poverty such as psychological stress, poor health styles, etc.

Social care professionals recognised key risk factor for poor educational outcomes but tended to focused on family and the community influences i.e. in a more social context. There was recognition of the key risk factors relating to poor educational outcomes but the emphasis of cause was on the family and the myriad of complex relationships and subsequent impact on a child, as well as the association of poor outcomes due to poverty.

The data indicated a degree of commonality with regard to identified risks despite their respective a slants on their understanding. Although there were similarities in risks factors identified, the way professionals saw a child was nonetheless different and often within that narrow professional lens. However, the understanding was complemented by each other’s professional expertise. This aspect was particularly evident within the findings stemming from the field trial undertaken (see Stage 3: Analysis of Findings).

The professionals, as a collective group, understood the variety of risks evident within the community. Indeed, the comprehensive collective understanding of the
level of need within the community was marked. Each professional, utilising their own area of expertise, was able to contribute to significant understanding of the risks for poor educational outcomes that underpinned the community studied. The concept of risk seemingly united the professionals in their understanding of the whole child. Each professional brought their own perspective within a common framework with the outcome of shared understanding and strategy.

Professional differences are evident but through the use of the term ‘risk’ the research evidence demonstrated that professionals may be united in their understanding of what are the risks that face children for poor educational outcomes.

3. How congruent are they with understandings of risk in the research literature?

The data stemming from the interviews, questionnaires and case study relate well to the literature regarding defining what the predominant risk factors are for poor educational outcomes. Within the data collected, comparable micro, meso and macro level risks are all evidenced in the earlier section of Findings in Chapter 4.

Table 16 in Chapter 4 (p.260) indicates the major risk factors that researchers such as Corcoran and Casebolt, 2004; Fraser, M.W., & Galinsky, M.J. 2004; Statham, 2004; and Masten and Coatsworth, 1998, have highlighted consistently over the last decade as having a high correlation with the research undertaken within this thesis.

The association of poverty and poor educational outcomes was evident within the findings and was consistent with the literature review, for example. Schoon et al., 2004; Schoon, 2003; Smith and Carlson, 1997., & Swadener and Lubeck, 1995.
Table 17 (p.262) further indicates a high correlation of related protective factors and resilience, respectively, from the literature review compared to research undertaken such as Gutman et al., 2010, Stein 2005., and Masten, 2001.

Thus, the research data appears to contribute to scholarly knowledge on a theoretical level with regard to professional conceptualisation and extends the literature review findings available through the context of a deprived inner city area within the England. The data collected from the professionals involved provides a useful insight into the particular difficulties children and families that they worked with. The findings stemming from the data also parallels the literature available, indeed, there was a high correlation of risk and resilience factors between the research and literature review and thus this study provides added validity to prior research.

4. How do these professional understandings shape the interventions with children that different professionals propose and what are the implications for the possibility of co-ordinated and effective interventions?

It is clear from the evidence pertaining to this research that the professionals tended to use their own understanding of children to inform interventions. At ground level, with the key practitioners working with case study pupils, there was little evidence of a coordinated strategy, their own knowledge and skills tended to inform their respective practice. Several different practitioners stated that interventions were implemented, for example, through; “own understanding” (Counsellor); “own observation” (Learning Mentor); “through talking to the pupil” and by “disclosures by and presentations of the pupil” (Form Tutor). Thus, individual constructs appear to determine intervention rather than a coherent and coordinated strategy.
The research also indicated that professionals, particularly at management level, had different conceptualisations which were discipline specific. For example, the Horticulturist and Clinical Psychologist frequently used medical constructs and ideologies when working with children, and social care professionals tended to use social model constructs. As seen in Chapter 4, the different conceptualisations the professional held were often exemplified in the language used by them.

The findings thus clearly demonstrate some of the issues found in the literature with regard to effective collaboration. The different ingrained cultures, (Robinson and Cottrell, 2005) conceptual understanding and ‘professional language used’ (I&D A, 2009, p.10) that was referred to in the review of literature were certainly borne out in the findings within this study. The different conceptualisations held by professionals within the study were evident and these different conceptualisations appeared to make collaboration hard as children were seen differently, leading to no real coordinated provision. However, there was a degree of overlap amongst professionals working within the case study school and when combined with a catalyst, in this case the risk and resilience framework, a shared understanding was reached. Professionals were able to build on what they had in common rather than on their own conceptualisations.

The research data appears thus to contribute to scholarly knowledge with regard to professional conceptualisations and the role these play in facilitating or hindering collaboration. The research findings indicated that professionals do see children differently and that having a common framework upon which to understand and intervene is important if such interventions are to be effective.
5. Is the risk and resilience framework a viable one to utilise by professionals from across the key children’s services, in order to develop a shared understanding of the child and thus ensure coordinated and effective interventions?

The testing of the framework through the field trial referred to in Chapter 4 (Stage 3) highlighted the possibilities that professionals had when utilising the risk and resilience framework to improve a pupil’s educational outcomes and indicated that this framework was productive.

The field trial demonstrated how a risk and resilience framework might be used for the future amongst the different agency professionals. The shared cumulative knowledge stemming from the meeting appeared to enable a better understanding of the pupil’s specific needs and increase the capacity of professionals to meet those needs more effectively than had previously been the case.

The importance of the field trial should be highlighted, as using the language of risk appeared to allow professionals to develop a shared understanding and shared strategy to thus improve educational outcomes. The framework brought professionals conceptually together for the first time - a conceptualisation of the child from different professionals with different perspectives appeared to be reached using a dialogue that was shared and appeared to be understood by all that took part in the study.

The framework seemed to allow professionals to see more of the child unlike the constraints for example, of a needs or problem framework. The notion of risk looked to be a useful way of allowing professionals to identify different types of risks and was thus not exclusive or limiting. As previously mentioned, having to actually specify what the child is at risk of is helpful as opposed to saying that the child is ‘at risk’ which says little about the actual situation or ways of improving
outcomes. Looking at the risk factors for poor educational outcomes and, thereafter, the protective factors, appeared to inform the subsequent intervention plan. Thus, the framework provided a ‘platform for decision making’ (Little, 2003, p23.) and allowed those present to address the concerns surrounding the child.

The findings indicated a need for a common framework to be utilised by professionals across the key children’s services and the risk and resilience framework appeared to be an effective way in unifying different professional perspectives to establish a shared understanding of the child, and to thereafter coordinate provision through shared concerns and priorities. Thus, the risk and resilience framework may be considered to be helpful. The field trial demonstrated that the risk and resilience framework could be a possible way forward for future working with other children in the school. The research thus provides some tangible and original evidence, though limited, that adds to scholarly knowledge.

**Contribution to knowledge: Locating the findings within the literature.**

This section considers the research field data in relation to the key findings of the review of literature undertaken. Evidence collected from the interviews, questionnaires and field trial indicates that there is congruence with the understandings of risk, protective factors and resilience and with regard to the difficulties of multi-agency collaboration in relation that emerged from the literature review.
Risk, protective factors and resilience

The most commonly identified risks and protective factors that researchers, such as Schoon, 2006; Fraser, 2004; Williams, 2001; Masten and Coatsworth 1998, specify have indicated a high correlation with the findings.

Further, the findings support previous research such as by Fraser 2004; Smokowski, 1998; and Masten, 1994, concerning the main ways of reducing risk and promoting resilience. The review of literature highlighted common ways of reducing risk and building resilience i.e. through a) direct intervention b) reducing stressors c) increasing services and resources to vulnerable communities and d) mobilizing protective processes. The type of resilience strategies that surfaced in the findings indicate congruence with the review of literature.

The findings suggest that the key children service providers all used interventions commonly considered appropriate by the above researchers, dependent upon management position. There was evidence the professionals used direct interventions, for example, through counselling and anger management programmes, and methods to reduce stressors through for example, engaging parents through Webster Stratton and building inter familial relationships in order to combat dysfunction that could lead to poor educational outcomes.

In terms of mobilizing protective processes there was a degree of congruence as some of management professionals within this study were able to dedicate appropriate personal to ensure protective processes were in place for some of the most vulnerable children as evident within the child case studies undertaken. However, with regard to increasing services and resources to vulnerable communities there was little evidence of congruence in the actual determination of provision of social support. While the management tier of
those interviewed may have directly influenced service and resource allocation to such support mechanisms, some of the professionals and practitioners only really signposted vulnerable families to them.

**Multi-agency work**

Some of the difficulties and benefits associated with multi-agency working were evident during the course of interviews, questionnaires and in the field study which related to the review of literature. The study both confirms and advances this particular field through its data findings relating to the barriers and facilitators to multi-agency collaboration, the difficulties relating to lack of a common language and different conceptualisations held by professionals.

When undertaking the research, certain themes began to developed that showed a strong correlation with that of Atkinson et al’s., (2007) summary of factors that both facilitated and challenged effective multi-agency work, both cultural and organisational.

The evidence from the findings revealed difficulties with status connected to role, competing priorities, understanding of the role and responsibilities of other practitioners, poor communication, problems of sharing information; divergence of objectives, differing protocols, different pay and conditions, conceptual differences and own professional cultural terms of reference. These difficulties all correlate to Atkinson et al’s., (2007), four main categories underpinning multi-agency working i.e. working relationships; multi-agency processes; resources for multi-agency work; and management and governance.

The difficulties and differences of thresholds for intervention sometimes caused difficulties amongst the professionals within this research. The different characteristics of thresholds within social care work influenced whether a case was open to discourse, or not allowing discourse to take place, or closed was not
always understood by other professionals, especially education, leading to frustrations and mistrust. The different organisational characteristics amongst the key children’s service providers were often not understood and this impacted on discourse between the professionals, often leading to misunderstandings and, at times, lack of engagement.

The different training, values, customs and culture experienced by the professionals across the key children’s services all impacted upon the way they conceptualised a child and on the way they talked about the same child (Atkinson et al., 2002).

The findings indicated that there was clear evidence of criticism with regard to each other’s service - in terms of delivery, personnel involved, communication and ways of service working. However, one interesting finding was the absence of a call amongst the professionals and practitioners of the need for multi-agency training which was so evident in the literature (Allnock et al., 2006, Anning, 2005 and Watson et al., 2002).

The findings in Chapter 4 indicated that, as we saw in the literature review (for example, Tomlinson et al., 2007), the professionals interviewed all recognised the importance of multi-agency collaboration. There was recognition of the benefits that multi-agency working brings in terms of having a more holistic understanding of the child and of the need to enhance relationships and working practices if children’s educational outcomes were to improve.

However, one aspect within the findings that was particularly pertinent, and which possibly adds depth to current literature on multi-agency working, was the evidence relating to the degree of overlapping and complementary understanding of risk factors amongst professionals despite the cultural and organisational differences.
The findings outlined in Chapter 4, indicated that there was difference in the language used by professionals working in the same settings which was derived from background experience and was often complex and jargonistic. This was particularly evident within discourses held with health professionals and often caused problems in terms of collaboration. The findings also indicated a need to develop a shared common language if multi-agency working is to be effective, as use of language influences perception, intervention and shared understanding.

The difficulties of multi-agency work arising from the research serves as confirmatory evidence that already exists with the literature review, in particular, that working within a theoretical framework dominated by a service provider can cause problems in terms of collaboration across agencies. There was some evidence that suggested that health practitioners tended to dominate multi-agency discourses and marginalised other professionals ‘views of the world’ (Dyson et al., 2009). Indeed, health professionals with their medical training and well researched, evidence based frameworks, tended to dominate meetings, and marginalised the approaches and ideology associated with social care and educational professionals. The research thus showed some congruence with the review of literature regarding health’s dominance over the approaches and ideologies other professionals (Abbott et al., 2005).

Certain success factors for effective multi-agency practice identified such as effective communication and appropriate information sharing processes as cited by, for example, Sloper (2004) and Atkinson, Doherty and Kinder (2005), were evident in the findings. However, there was no real consistent effective multi-agency practice within the school concerning the case study pupils. The exception really came with the child with a statement of special educational needs and LAC status which correlates with the review of literature concerning small scale studies of effective multi-agency working with children with disability, etc, e.g. Mailin &
Morrow 2007; Soan, 2006; Townsley, 2004; Glenny, 2005; and Milbourne et al., 2003.

Some of the difficulties that the research highlighted of multi-agency working are comparable to the continued difficulties outlined in Lord Laming’s Progress Report (DCSF, 2009) For example; "over-emphasis on process and targets" (p.22) was congruent with social care in this study; “good examples of joint working too often rely on the goodwill of individuals” (p.36) is comparable to a views held by education professionals as seen earlier in Chapter 4. The findings within this study highlighted the difficulties of multi-agency working within a context of a secondary school.

As Lord Laming stated:

> Despite considerable progress in inter agency working ....there remain significant problems in the day-to-day reality of working across organisational boundaries and cultures (2009, p.9).

**Professional conceptualisations**

The study also indicated professionals held different conceptualisations of children and that interventions were often not coordinated effectively due to these divergent professional opinions and misunderstanding of each other’s role and working practice, which often led to critical opinions of respective professionals.

The different conceptualisations professionals held made effective collaboration difficult. However, the findings also indicated that the professionals had a degree of commonality in their understanding of children and provided indicative evidence that to get beyond these difficulties the use of a shared conceptual framework, in this case the risk and resilience framework, could be productive.
The field trial indicated that the framework supported collaborative practice on an equitable basis. Certainly, all professionals and the parent were able to have a better shared understanding of the child’s needs. The professionals and parent were able to plan together using the risk and protective factors and own expertise to impact on improving the trajectory of outcomes.

Howard et al., (1999) questioned if professionals would agree with one another’s understanding of risk and resilience. In the field trial, there was an indication that considering the risk and protective factors was understood and I was able to categorise responses into clear micro, meso and macro factors that corresponded well with those from the research literature. The responses appeared to surface the actual risks to which the child was subject to. Further, as Jenson and Fraser (2011) suggest, the professionals, and the parent, were able to surface their own assumptions without too much jargon which lead to a clarity of shared conceptualisations and actions. The only aspect that was not expanded upon in the meeting was the concept of ‘attachment disorder’ which was not explained but merely accepted by those present. Indeed, I did not ‘challenge’ the use of this medical term as suggested one should do by Frost (2005, p.52.) partly because I had a ‘lay’ understanding of the term and because the discussion that led to this term was possibly understood within the context of the child not wanting to leave his mother. However, with hindsight, this may have been a typical misconception on my part and it was perhaps remiss of me not to have checked if I and others had a correct understanding.

The field trial indicated that professionals were seemingly able to address both risks, such as non attendance to school, low self esteem and poor family discipline and the ways of developing future protection from presenting risks, such as implementing strategies to build on protective factors such as the good family support, high cognitive ability and willingness to learn within a more supportive
school environment. Thus, it appeared that those present were able to understand the difficulties that the child faced, thereby informing the subsequent intervention plan. The meeting, through the underpinning framework, seemed to help surface the previously unmet needs of the child through the analysis of the predisposing risk and protective factors. It appeared that the professionals and parent were able to “foster the child’s inherent strengths and resilience, and where impairment exists to bolster their coping strategies” (Little, 2003, p.22).

**Risk and resilience framework**

There are several conceptual frameworks that may be used to develop a common understanding and these are outlined in Chapter 2: Literature Review. However, for the purpose of this research, the risk and resilience framework was explored for the following reasons.

The framework may be considered ‘neutral’, it is not ‘owned’ by education, health or social care. It allows for a ‘common language’, collaborative practice on an equitable basis and ensures a shared understanding and thus a shared strategy. The framework allows professionals to plan together and utilise their own area of expertise to impact on the child, as well as also encouraging beyond professional sector boundary understanding. Separate professionals are able to have their own professional discourse and fit with the risk and resilience framework. Thus, the latter could be made use of in terms of multi-agency working.

Schoon and Bynner (2003, p.26) suggested that the framework “allows a holistic approach in terms of interventions and satisfies the need for integrated service delivery.” The field trial appeared to bring the professionals together and, at the same time, allowed all present to use their specific areas of expertise to impact on the child. At the developmental multi-agency meeting, health tended to focus on certain obsessions that the child had with clothes, food and rituals, as well as on
medical significance of having ASD. Education tended to focus on the issues of non attendance, lack of engagement and behaviour. The Parent Partnership Worker tended to focus on family issues such as sibling conflict and bullying within the home environment and the difficulties of the parent to manage the specific behaviour of the child. Bringing this expertise to the table collectively was beneficial as the field trial indicated that by using the framework professionals were able to have a clearer to understanding of the specific context surrounding the individual and put in place strategies to affect improved outcomes for the future.

The framework appeared to enable professionals to build on a shared understanding and be an effective catalyst in allowing them to go beyond separate conceptualisations facilitating more open dialogue to improve educational outcomes. The framework seemed to allow the perspectives to come together which led to a unified strategy of support (Corcoran and Casebolt, 2004; Fraser et al., 1999; Howard & Jenson, 1999).

The study thus makes a practical contribution to research through its exploration of the risk and resilience framework within a specific child case context. The research also showed that despite differences amongst professionals, there is nonetheless a degree of overlap and complimentary understanding of pupils did they but realise it.

The review of literature indicates that risk and resilience framework has potential to bring professional together to plan and ensure own area of expertise impacts upon the child. Indeed, there appears to be growing advocacy for the framework. As Anthony, Alter and Jenson, (2009) state:

The risk and resilience framework has great utility because it has the potential of unifying policy and program development across a wide range of service sectors. The framework provides common ground for
policymakers and program designers of different ideologies. Those from a problem orientation can identify with a framework that rests on an annunciation of risk; those from a strengths perspective feel at home with the focus on protection and promotion of resilience. The framework can easily cross disciplinary boundaries. Professionals trained in the medical and psychological traditions can focus on the internal dynamics (promoting resilience) of high-risk children while social workers and public health workers can concentrate on the social aspects of children's lives through building external protections (no page reference given: Internet 2011).

Summary

The different conceptualisations, different cultures, competing priorities, communication difficulties, etc, evident within the findings in Chapter 4, exemplified the difficulties found in the literature review. This thus suggested a different way of working together was perhaps needed for professionals to work more effectively together in order to improve educational outcomes for children.

The need for professionals across the key children’s services to have a common language and a framework in which to understand children together and in which to ensure effective joint working is clearly apparent from the review of literature and from the findings within this study.

Given the difficulties of multi-agency working, a conceptual framework to build a shared understanding and allow open dialogue using a common language was considered to be a way useful forward. The research thus explored the use of a risk and resilience framework to develop common conceptualisation and a shared language; one that unites professionals across education, health and social care in a shared understanding of individual need and one that also addressed the entrenched cultural and assumptional differences that exists between the service providers.
The risk and resilience framework was thus utilised within an individual case study to see if it provided a unifying structure upon which professionals from across key children’s services could negotiate and build an effective strategy based on risks and aspects of resilience. The outcome from this study appeared to be productive. Indeed, as Anthony, Alter and Jenson state: “a risk and resilience framework holds great promise as such a unifying framework” (2009: no page reference given: Internet 2011)

The need to move on from previous ways of multi-agency working is clearly evident given the continued prevalence of challenges of multi-agency working. There are clear issues of expertise, identity and power that need to be resolved (Rose, 2011). It is evident too that there is a need for a shared language that is agreed and understood by all practitioners (Fitzgerald and Kay, 2008). Thus, the importance and relevance of the findings within this research and their contribution to scholarly knowledge.

The study has contributed to knowledge theoretically by verifying much of the literature with regard to multi-agency collaboration, as well as risk, protective and resilience factors in relation to educational outcomes. The study has also contributed to knowledge from a practical point of view: that the risk and resilience framework may be used to a good effect within the context of a school. Previous research utilising the risk and resilience framework involving key children’s services was based within a mental health setting (Croom and Proctor, 2005). The study, to my knowledge is unique, in that it focuses on an inner city school community. The literature search has found no comparable research.
Limitations to the study

The limitations of this thesis are exemplified within the main body and are summarised below:

With regard to the literature review
The review of literature was predominantly undertaken in the wake of Climbe’s death and the subsequent call for an integrated service delivery. This was consistent over a ten year period. Inevitably with a change of government in May 2010, there are now different priorities and a more local model of service delivery. However, the research remains pertinent in that it looks at how professional conceptualisations impacts on provision and explores a conceptual framework that allows professionals to have a shared understanding and common language to improve educational outcomes.

With regard to methodology
i) Utilisation of case study and its wider contribution to knowledge
The limitations of case study, due to its restricted application to other contexts, are considered in the methodology section. The main criticism of case study research rests in its reliability and that other researchers may come to differing conclusions. However, the research data collected for the purpose of this research incorporated various sources, allowing for “in depth understanding of the entity” (Borg and Gall, 1989, p.402).

The benefit of using case study certainly allowed me to be fully ‘immersed’ in the data and an in depth perspective of a ‘real life setting.’ The research undertaken gave me firsthand experience in seeking a full and better understanding of the multi-agency relationships and insight into the differing relationship dimensions within the school studied. The data collected was ‘varied and sufficient in quantity
to draw valid conclusions’ (Anderson, 1990, p.159) but there remains researcher scepticism about case study design.

The interviews, questionnaires and field study are supported by a considerable data bank. The process of data collection and methods of analysis are shared as much as possible within the course of this study allowing for accountability with regard to conclusions reached. Further, the research undertaken may well serve to initiate a larger study in the future.

ii) Utilisation of qualitative research
The research is predominantly reliant upon qualitative research methodology and is thus subject to various aspects of criticism such as internal validity and bias of interpretation. Again, these aspects are considered earlier in the thesis.
Throughout the collection and interpretation of data, I utilised triangulation prior to conclusions drawn and was rigorous in striving for objectivity. The research undertaken was with a particular school, with particular professionals and pupils between 2006 -2008. The data collected was undertaken with ‘rigour’ and the reader, due to the data collection undertaken, may make their own judgement as to its wider application.

iii) Utilisation of only one field trial involving the specific use of the risk and resilience framework
Although the research indicated a need for a unifying structure in which to understand children and explored if a shared conceptual framework helped effective multi-agency working, I acknowledge that from only one field trial a very limited conclusion may be drawn.

This circumstance came about due to a change of job and thereafter, a lack of comparable situation in which to carry on the research. Furthermore, due to time constraints, I was unable to interview participants as to their views regarding the
use of the risk and resilience framework. This would have clearly given a useful insight into the framework’s use and thus give greater depth to the research.

Caution in interpreting the data has thus to be considered. The data is clearly limited due the solitary of this field study. Other examples of the utilisation of the framework with other key service representatives, with different children and within a different school or organisation may well have provided different results.

Complexities of the role of researcher and practitioner

The complicated relationship between the researcher as a practitioner and as researcher including the line management aspect of those involved in completing questionnaires was complex.

There were certain ethical complexities pertaining to the research undertaken that as a practitioner I had to take into consideration. I was very aware that there was a certain privileged to the role I had within the case study school - I was a Deputy Head in charge of inclusion and had easy access to records and professionals. The hierarchical nature of my role had to be put to one side in order to respect ethics bounded with the research.

The research was carried out in my own work place environment predominantly with those whom I had a professional relationship with which was helpful. Despite my ‘privileged position’ aspects of reliability, validity and trustworthiness are perhaps even more called into question when one is both researcher and practitioner within the case study setting. However, I have reported the findings as accurately and objectively as possible. I have at all times tried to be as consistent as possible in carrying out fieldwork undertaken and transparent in how findings were reached.
The balance between researcher and a known professional was difficult as, at times, some of the professionals ‘off loaded’ onto me. Aspects of confidentiality clearly had to be upheld while ensuring data findings were accurately and ethically reported. The rigour in undertaking analysis, being consistent and coming to conclusions through transparent evidence was of paramount importance.

Balancing the dual role of part time researcher and full time Deputy Headteacher was hard but manageable due to regular supervision given and critical friend support. Time management was essential and at times proved to be difficult, dogged perseverance being the key.

In the main, the research process went well but the study was restricted to one particular school community at a give time and place. Had I had been permitted more time, I would have liked to have gathered additional qualitative data from other practitioners and professionals involved with the case study school.

Further, I recognise that undertaking a comparable study in a different school may have contributed to the reliability of the research. As this research was conducted in only one secondary school, further research on a larger scale is necessary to verify or refute my findings. It may have proved interesting to see what the responses would be in comparable schools with professionals, practitioner and pupils that I had not worked with.

Reflections

With hindsight, some aspects of the research would have been undertaken differently. I would have liked to have interviewed the same number of
professionals and practitioners across the key service providers to give greater equity and depth to the data findings.

Some of the participants were practitioners for more than one of the case study children and thus some of their answers were repetitive. Two of the interviewees were both line managers and practitioners to more than one of the case study pupils and thus their answers tended to be more generic than individualistic.

Further, I would have used an ICT software package with regard to questionnaire responses given the time involved to collect, collate and record responses.

I would certainly have broadened the research to other school settings and undertaken more field trials with regard the use of the risk and resilience framework. Further, I would gather data to find out professionals responses to its use to verify usefulness or not.

Finally, over the course of this research, following the interviews and questionnaires, my views of the different perspectives of professionals evolved. I became far more aware of the myriad of factors that contributed to professional perspectives. I acquired greater insight and depth of understanding of the professionals I worked with and, as a researcher, I was able to learn much from them. I became more knowledgeable with regard to their underpinning beliefs and principles, as well as the constraints that all professional groups appeared to be under. I was able to examine my own practice in the way I worked with other professionals and how my own professional values and knowledge impacted on other professionals. I had not really considered my own parochial attitude and the effect it had on other professionals. I had not realised the depth of discordance across the key children’s services and the research gave me a salutary reminder as to the importance of working together, understanding and respecting each other’s roles and responsibilities.
Implications for policy and practice

Professional conceptualisations clearly play a key role in facilitating / hindering multi-agency collaboration. The implications for policy and practice are for the risk and resilience framework to be considered as a way forward to enhance multi-agency collaboration by key children’s services to understand the needs of vulnerable children better, to implement a common language and to allow a more coherent and effective delivery of service interventions.

The potential to further research the practice of using the risk and resilience framework within a school context may well be beneficial if multi-agency work is to be effective. Only through such shared conceptualisation and language, and thus effective collaborative work, will the vulnerable children who we serve have a potential trajectory for positive educational outcomes.
Bibliography


DYSON, A., LIN, M., AND MILLWARD, A. (1998). Effective communication between schools, LEAs and Health and Social Services in the field of special educational needs. Sudbury: DfEE.


Appendices

Appendix 1  Definition of terms relating to multi-agency activity

Joined-up: Deliberate and co-ordinated planning and working, takes account of different policies and varying agency practice and values

Joint working: Professionals from more than one agency, working directly together on a project.

Multi-agency/cross-agency working: More than one agency, working together. Service provided by agencies acting in concert and drawing on pooled resources or pooled budgets.

Multi-professional/multi-disciplinary working: Working together of staff of different professions, background and training.

Inter-agency working: More than one agency working together in a planned and formal way.

Cross-boundary working: Agencies working together on areas that extend beyond the scope of any one agency.

Cross-cutting: Cross-cutting issues are those that are not the ‘property’ of a single organisation or agency. Examples include social inclusion, improving health, urban regeneration.

Integration: Agencies working together within a single, often new organisational structure.

Networks: Informal contact and communication between individuals or agencies.

Collaborative working/collaboration: Agencies working together in a wide variety of different ways to pursue a common goal while also pursuing their own organisational goals.

Co-operation: Informal relationships between organisations designed to ensure that organisations can pursue their own goals more effectively.

Co-ordination: More formal mechanisms to ensure that organisations take account of each other’s strategies and activities in their own planning.
Appendix 2
Common risk, protective and resilience factors taken from the review of literature: (Schoon et al., 2004; Luthar et al., 2000; Silliman, 1998; Smith and Carlson, 1997; Swadener and Lubeck, 1995; Grotberg, 1995; Bernard, 2004; Ungar 2004; Najman et al., 2003; Werner and Smith, 2001; 1992; Howard and Johnson, 1998; Masten 1994).

Common Risk Factors
Refugee / asylum seeking status
Domestic violence
Poverty
Poor educational attainment – familial illiteracy
Educational failure
Minority ethnic families
Principle carer overwhelmed
Looked After Status
Special Educational Needs
Parental criminality
Poor education
Marital discord
Family dysfunction
Early sexual experience
Foster placement
Large families
Serious accident
Discrimination
A move to a new area / neighbourhood/mobility
Gender specific related risks

Physical health
Physical disability
Temporary/ chronic/acute physical ill health
High attendance at A&E
Poor nutrition / hunger
Bedwetting / soiling

Mental / Emotional Health
Specific emotional or conduct disorder
Temporary/ chronic/acute mental ill health
Poor social skills
Low self esteem
Stress
Depression
Suicide attempt / self harm
Antisocial behaviour
Family dysfunction
Low warmth / high criticism household
Poor parental relationship
Poor parental discipline
Overt discipline
Substance misuse
Alcohol misuse
Teenage mothers
Maternal psychiatric disorder
Trauma / catastrophic life events
Death of close relative

**Maltreatment**
Child ill treated / neglected by parent/sibling/relative/other – sexually, emotionally or physically
Bullying
Domestic violence

**Environment / Community**
Community violence
High crime within community
Poverty
Overcrowding
Poor accommodation
Temporary accommodation
Socially isolated
Single parenthood
Unemployment
Homelessness
Safe housing
Appendix 3
Protective / resilience factors (Masten and Coatsworth, 1998, Fraser 1997; Williams, 2001)

Micro
Positive self esteem
High self regard
High cognitive ability
Talent
Sense of belonging
Secure base
Sense of identity
Resistance to oppression
Friendship positive attachment to a significant adult
Social support
Warm, caring relationship
Accomplishment in tasks / positive experiences
Self efficacy
Academic attainment
Good health
Effective parental advocates
Good education
Easy temperament
Emotional literacy
Family cohesion
Competent parental skills
Positive reinforcement
Family resilience
Personal responsibility and autonomy;
Creative problem-solving skills;
Social competence; an ability to tolerate frustration and manage emotions; a feeling of personal control over ones life and self-Confidence
Optimistic outlook;
Persistence in the face of failure;
Experience with self-mastery;
Humour
An ability to seek out support
Sociability

Meso
Effective schooling
Adequate resources within health services – nutrition and health care
Appendix 4  Interview Questions

- How would you define children at risk of poor educational outcomes?
- How to you specifically identify children who you consider to be at risk of poor educational outcomes?
- What is your understanding of the risks that children face within this specific community?
- What do you consider to be the major concerns / or risks for children in your care?
- What factors enable a child to become resilient to the difficulties / problems encountered?
- What is your understanding of the word resilience?
- What specific intervention strategies do you deploy to lessen risk?
- How does your organisation build / promote resilience within children?
- Which agencies do you particularly engage with regard to children at risk?
- Is multi-agency working and inter agency liaison effective?

Appendix 5  Questionnaire questions

- What is your understanding of the main difficulties or risks that this pupil faces: Socially and Educationally?
- How have you supported this pupil to overcome the risks faced: Socially and Educationally?
- How has your intervention been determined?
- Has the intervention been effective – give examples where possible?
- What is your understanding of the word resilience?
- How have you built the resilience within the pupil to ensure risks faced are lessened of reduced?
- What other factors do you consider have helped build resilience within this pupil, both socially and educationally?
- How typical is this child of all those you deal with?
- Is this child representative of many children within this locality?
What impact do you consider your involvement has had on this particular child?

Appendix 6  Example of how each interview question the data from the interviews was organised and tabulated according to questions asked, individually and by profession in summary form. Each interview question response was put under the relevant question heading according to service representation and recorded in table format.

How would you define children at risk of poor educational outcomes?

<table>
<thead>
<tr>
<th>Education</th>
<th>Behaviour Support Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not making SATs grades. Looked After Children. Parents who have not succeeded and therefore education is not supported; non attendees; work ethic missing for some parents /carers; children at risk of child protection; children with ASBOs at a young age. There is little support for parent / carers. If the support is not there the children have no chance. There has to be joined up support between home and school if the child is to succeed.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>Headteacher 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational disengagement – without ability to access preferred learning style; without ability to access school structure.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>Headteacher 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where the individual child is not taught; material not broken down in the way they can understand, not differentiated, whole class is taught not the individual. This leads to frustration, the child acts out and behavioural issues e.g. walk out of class – there way of coming; to find a way out. Not behaviour issues per se – reaction to not being taught. No one in school to talk to someone in school to talk about issues in schools and strategies to deal with them.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>Outreach Worker 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance, behaviour - exclusions, SATs / GCSEs results- very important. Qualifications are important and apprenticeships. Exclusions can be positive – clamp down, drive to change ethos of school and staff. Social deprivation; low income families; health issues; learning and mental health needs/ issues, misusing drugs, or exposed to, substance misuse; issues of bullying within school or environment; lack of a positive role model within the school setting or in general. Influence from peers – being unable to make right choice for fear of being isolated or bullied – follow the crowd and follow the gang.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>Outreach Worker 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The child with low self esteem, problems with social interaction with their peers, those unable to access the curriculum for a variety of reasons –learning, disengaged because of behaviour issues; child having or exposed to difficult home situations or outside school that might impact on learning. Poor economic background, lack of adequate resources e.g no after school provision / activities, living in huge crime related areas , poor social peer groups</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>Psychology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children who are experiencing poverty, relationship conflict and general lack of care by adults. Feeling of failure and defeat in school, some don’t go to school as it is not seen as valuable or worthwhile. School is often regarded as a horrible experience.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where there is huge deprivation, we serve in one of the poorest areas in Manchester – pupils have a translucent look due to lack of nourishment – they look poor both the</td>
</tr>
<tr>
<td>Role</td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Senior Practitioner</td>
</tr>
<tr>
<td>Social Care Lead Social Care Manager</td>
</tr>
<tr>
<td>Social Care / LAC Worker</td>
</tr>
<tr>
<td>Family Support Worker 1</td>
</tr>
<tr>
<td>Family Support Worker 2</td>
</tr>
<tr>
<td>Health / Therapeutic Horticulturist</td>
</tr>
<tr>
<td>Health (Art Therapist)</td>
</tr>
<tr>
<td>Counsellor</td>
</tr>
</tbody>
</table>
Appendix 7  Resilience factors as identified by interviewees

<table>
<thead>
<tr>
<th>Education</th>
<th>Health</th>
<th>Social Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strength of child</td>
<td>Meaningful &amp; significant relationships</td>
<td>Significant adult / other / a role model</td>
</tr>
<tr>
<td>Role model</td>
<td>Role model</td>
<td>Unconditional love</td>
</tr>
<tr>
<td>Understanding of self</td>
<td>Aspirations</td>
<td>Development of coping skills</td>
</tr>
<tr>
<td>Sense of identity</td>
<td>Positive experiences</td>
<td>Environment in which they live</td>
</tr>
<tr>
<td>Self esteem</td>
<td>Ability to shine at something</td>
<td>Having routine and structures</td>
</tr>
<tr>
<td>Emotional skills</td>
<td>Positive adult relationships</td>
<td>A good Carer</td>
</tr>
<tr>
<td>High aspirations</td>
<td>Opportunities to explore feelings</td>
<td>Siblings</td>
</tr>
<tr>
<td>Supportive home life/ Parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having successful experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant adult including relatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intelligence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult modelling</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Appendix 8  Data analysis stemming from questionnaire

Social and educational difficulties identified by practitioners

<table>
<thead>
<tr>
<th>Difficulties faced by pupils</th>
<th>Pupil A</th>
<th>Pupil B</th>
<th>Pupil C</th>
<th>Pupil D</th>
<th>Pupil E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Different culture</td>
<td>*</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Different environment</td>
<td>*</td>
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<td></td>
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<tr>
<td>Different language</td>
<td>*</td>
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<tr>
<td>Self confidence</td>
<td></td>
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<tr>
<td>Low self esteem</td>
<td>*</td>
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<td>*</td>
<td>*</td>
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<tr>
<td>Making friends</td>
<td></td>
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<tr>
<td>Easily led</td>
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<tr>
<td>Emotional difficulties</td>
<td>*</td>
<td>*</td>
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<tr>
<td>Being different</td>
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<tr>
<td>Wishing to forget past</td>
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<tr>
<td>Underachievement</td>
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<tr>
<td>Uncertain future</td>
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<tr>
<td>Not understanding friendships</td>
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<tr>
<td>managing emotions positively</td>
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<tr>
<td>managing conflict</td>
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<tr>
<td>aggressive verbal &amp; non verbal</td>
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<td>forms of communication</td>
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<tr>
<td>Lonely</td>
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<tr>
<td>Immature behaviour</td>
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<tr>
<td>Emotionally young</td>
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<tr>
<td>Learning difficulties</td>
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<tr>
<td>Lack of social understanding</td>
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<tr>
<td>Vulnerability</td>
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<tr>
<td>Behavioural difficulties</td>
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<tr>
<td>Anti social behaviour</td>
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<tr>
<td>Difficult to engage</td>
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<tr>
<td>At risk of exclusion</td>
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<tr>
<td>Child protection issues</td>
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</table>
## Appendix 9 Support strategies practitioners used

<table>
<thead>
<tr>
<th>Issue</th>
<th>Pupil A</th>
<th>Pupil B</th>
<th>Pupil C</th>
<th>Pupil D</th>
<th>Pupil E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of criminality</td>
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<td>Risk of gang involvement</td>
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<tr>
<td>Language</td>
<td>*</td>
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<tr>
<td>Finding relevance of subjects</td>
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<tr>
<td>Underachievement</td>
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<tr>
<td>Underachievement due to low ability</td>
<td>*</td>
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<tr>
<td>Finds lessons hard</td>
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<tr>
<td>Literacy and numeracy difficulties</td>
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<tr>
<td>Specific learning difficulties</td>
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<tr>
<td>Lack of home support</td>
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<tr>
<td>General learning difficulties</td>
<td>*</td>
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<td></td>
</tr>
<tr>
<td>Poor concentration span</td>
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<tr>
<td>Difficulty accessing the curriculum</td>
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<tr>
<td>Refuses to attend lessons</td>
<td></td>
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<tr>
<td>Negative attitude to school</td>
<td></td>
<td>*</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Anti authoritarian</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor attendance</td>
<td>*</td>
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<td></td>
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<tr>
<td>Emotional issues</td>
<td></td>
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</tbody>
</table>

- * indicates the strategy was used for the pupil.
## Appendix 10  Practitioner understanding of the term resilience

<table>
<thead>
<tr>
<th>Professional</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of Year</td>
<td>Strength and the will to see things through to the end. To deal with issues, problems, worries, anxieties and stress.</td>
</tr>
<tr>
<td>Form Tutor 1</td>
<td>A means to support potential troubles and emotions</td>
</tr>
<tr>
<td>Horticultural Therapist</td>
<td>A person’s ability to ‘cope with’ stressful, traumatic or negative situations without long term adverse effects to their mental health or general outlook on life.</td>
</tr>
<tr>
<td>Learning Mentor</td>
<td>When an individual is able to adopt strategies that can have a positive impact on their own learning</td>
</tr>
<tr>
<td>Teaching Assistant 1</td>
<td>This means not to give up.</td>
</tr>
<tr>
<td>Student Support</td>
<td>To keep trying, don’t give up. Not to feel you have failed if at first not successful but to keep trying. Not to let things knock you back, keep trying to get better quicker.</td>
</tr>
<tr>
<td>LAC Worker</td>
<td>Having coping mechanisms, even if this means you are able to cover a problem. This detracts a person’s attention in order to show everything is ok even when it isn’t.</td>
</tr>
<tr>
<td>Form Tutor 2</td>
<td>The ability to cope with and bounce back from stressful situations</td>
</tr>
<tr>
<td>Teaching Assistant 2</td>
<td>It is how you recover from insults or difficult situations you face.</td>
</tr>
<tr>
<td>Form Tutor 3</td>
<td>Never giving up; always trying your best.</td>
</tr>
<tr>
<td>Behaviour Support</td>
<td>Capacity to recover from physical / emotional blows</td>
</tr>
<tr>
<td>Behaviour Support Specialist 1</td>
<td>I see resilience as based on the belief that your own (and that of those who really care for you) opinion of yourself is more important than that of others, so that you are able to manage setbacks knowing that you will come out the other side. It is helpful to reflect on past similar situations that came and went without permanent damage.</td>
</tr>
<tr>
<td>Mentor 2</td>
<td>Never giving up; always keep trying.</td>
</tr>
<tr>
<td>Behaviour Support Specialist 2</td>
<td>Regarding this person very resilient but identified through his actions a quite problematic – anti social-criminal. Resilient in fact that he would take what he wants in order to exist – no conscience.</td>
</tr>
<tr>
<td>School Nurse</td>
<td>Ability to cope with the horrible things that life throws at you. The ability to get back up and keep going. Having a dedicated person on their side.</td>
</tr>
<tr>
<td>School Counsellor</td>
<td>Resilience is the process of self protection and level of strength and the degree of interaction and usefulness between the two. Children in general, from my personal and professional experience, are extremely resilient. They have the ability to hide feelings and hurt, or face people and circumstances when necessary and/or deal more or less successfully with stresses past and present.</td>
</tr>
<tr>
<td>Youth Intervention Officer</td>
<td>A resistance /dislike of either an expected outcome or authority or building a person’s tolerance or ability to face challenges</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Individual strengths – how they cope with change</td>
</tr>
</tbody>
</table>
Appendix 11 The data below indicates the risks that professionals believed that were present within the community. There are a wide range of recorded risks (34 specified) with areas of commonality, such as poverty and drugs, and differences, such as teenage pregnancy and racial tension, between all professionals. Indeed, 16 of the specified risks are recorded by one professional only.

Table B Risks within the community as identified through Interviewee responses

<table>
<thead>
<tr>
<th>Risk</th>
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<tbody>
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<td>Poverty</td>
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<td>Bullying</td>
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<td>Unemployment</td>
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<tr>
<td>Alcohol /drugs</td>
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<td>Family breakdown</td>
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<td>Poor life experiences</td>
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<tr>
<td>Overcrowding /housing</td>
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<tr>
<td>Anti social behaviour</td>
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<tr>
<td>Being safe</td>
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<tr>
<td>Domestic violence</td>
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<tr>
<td>Stress</td>
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</table>
### Appendix 12 Protective factors identified by practitioners

<table>
<thead>
<tr>
<th>Factor</th>
<th>Pupil A</th>
<th>Pupil B</th>
<th>Pupil C</th>
<th>Pupil D</th>
<th>Pupil E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support from all the people who care &amp; are a part of the child’s life</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Therapeutic involvement – (drama, horticulture, art etc)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended peer group support network</td>
<td>✓</td>
<td>✓</td>
<td></td>
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</tr>
<tr>
<td>Being the best at something or good at something e.g. sport</td>
<td>✓</td>
<td></td>
<td>✓</td>
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</tr>
<tr>
<td>Intelligence</td>
<td>✓</td>
<td></td>
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<td></td>
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<tr>
<td>qualities that build self esteem</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Stable school</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good school relationships,</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stable adults</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaging personality</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a mentor</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
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<tr>
<td>Long term involvement with pupil</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>Able to engage with peers and friends.</td>
<td>✓</td>
<td></td>
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</tr>
<tr>
<td>Experience</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Maturation</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Setting Goals / Targets</td>
<td></td>
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</tr>
</tbody>
</table>

- Abuse: 2
- Child death: 1
- Bereavement: 1
- Racial tension: 1
- Single parent: 1
- Child vulnerability: 1
- Trauma: 1
- Negative peer pressure: 2
- Special needs: 1
- Teenage pregnancy: 1
- No meaning of life: 1
- No work ethic: 1
Appendix 13 How practitioners build resilience with case study pupils

<table>
<thead>
<tr>
<th>Professionals</th>
<th>Pupil A</th>
<th>Pupil B</th>
<th>Pupil C</th>
<th>Pupil D</th>
<th>Pupil E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encouragement / Praise</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Created / facilitated and reinforced a peer group that faced similar issues</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Counselling for specific need</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>To instill self confidence</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Implement strategies to be assertive and not aggressive</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
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<tr>
<td>Socialization programmes</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
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</tr>
<tr>
<td>Providing safe environment / being there</td>
<td>*</td>
<td>*</td>
<td>*</td>
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</tr>
<tr>
<td>Regular discussions and dialogue with the pupil</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Pupil is able to seek help from named adults in school / building positive relationship</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>By giving simple goals, and creating a consistent set of routines,</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Building genuinely useful skills to take pride in.</td>
<td>*</td>
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</tr>
</tbody>
</table>

Appendix 14 Comparison of collective practitioner questionnaire responses as to the factors which are considered important in building resilience with regard to the case study pupils

<table>
<thead>
<tr>
<th>Child</th>
<th>Education</th>
<th>Health</th>
<th>Social Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Support</td>
<td>Extended peer group support network – of those with similar experiences -</td>
<td></td>
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<tr>
<td></td>
<td>Sport</td>
<td>Improve and participate in the areas in which he excels – particularly sport.</td>
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<tr>
<td></td>
<td>By encouraging him to face up to his problems in a mature, logical way.</td>
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<tr>
<td></td>
<td>To question his self beliefs and to have self confidence and be assertive and not aggressive</td>
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<tr>
<td>B</td>
<td>Socialisation programmes</td>
<td>Talking Stable adults Engaging personality Inner strength Having her regain control of certain parts of her life</td>
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<tr>
<td></td>
<td>Significant other</td>
<td>Talking Significant other</td>
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<tr>
<td></td>
<td>Encouragement</td>
<td>Encouraging</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Praise</td>
<td>Reinforce positives</td>
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<tr>
<td></td>
<td>Continuity of relationship</td>
<td>Supporting</td>
<td></td>
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<td></td>
<td>Support from those that care</td>
<td>Listening</td>
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<td></td>
<td></td>
<td>Family support</td>
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<tr>
<td>C</td>
<td>Setting targets to achieve</td>
<td>Getting her to take responsibility for own</td>
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<td></td>
<td>Building skills</td>
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<tr>
<td>Supportive school environment</td>
<td>Family</td>
<td>actions</td>
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<tr>
<td></td>
<td></td>
<td>Focus on positives</td>
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<td></td>
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<td>Leave aside ‘autistic sticker’</td>
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<td></td>
<td></td>
<td>Stability</td>
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<td>D</td>
<td>Emotional management</td>
<td>Over resilient</td>
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<tr>
<td></td>
<td>Encouragement</td>
<td></td>
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<td></td>
<td>Positive relationships</td>
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<td></td>
<td>Mentors</td>
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<td>E</td>
<td>Reverse negative mindset</td>
<td>Family love</td>
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<td></td>
<td>Encouragement / Engagement</td>
<td>Friendships</td>
<td></td>
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<tr>
<td></td>
<td>Building belief in self</td>
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<tr>
<td></td>
<td>Building social interactivity</td>
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<td></td>
<td>Positive / trusting relationship</td>
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<td></td>
<td>Empathy</td>
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<td></td>
<td></td>
<td>Work with him to understand emotional and mental needs</td>
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<td></td>
<td></td>
<td>Exploring achievable goals</td>
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<td></td>
<td></td>
<td>Enforcing curfews and interactions with agencies</td>
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<td></td>
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<td>Maturation</td>
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<td></td>
<td></td>
<td>Pupil ability to listen</td>
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</table>

Appendix 15   Barriers and facilitators to effective multi-agency work as indicated through research findings compared to those identified by Atkinson et al 2007 comparison

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fiscal:</strong> evidence of different pay and conditions causing a concern</td>
<td><strong>Commitment:</strong> no evidence</td>
</tr>
<tr>
<td><strong>Roles and responsibilities:</strong> lack of understanding and valuing other professionals’ roles; duplication of service provision; concept of health professionals as specialist</td>
<td><strong>Understanding roles and responsibilities</strong> – considered improving</td>
</tr>
<tr>
<td><strong>Competing priorities:</strong> target driven with social care</td>
<td><strong>Common aims and objectives:</strong> some evidence</td>
</tr>
<tr>
<td><strong>Non fiscal resources:</strong> no evidence</td>
<td><strong>Communication and information sharing:</strong> improving between CAMHS and psychology</td>
</tr>
<tr>
<td><strong>Communication:</strong> poor communication; ineffective sharing of information; jargon</td>
<td><strong>Leadership:</strong> no evidence</td>
</tr>
<tr>
<td><strong>Professional and agency culture:</strong> denigration of other professionals particularly about social care and health about education</td>
<td><strong>Involvement of relevant personnel:</strong> no evidence</td>
</tr>
<tr>
<td><strong>Management:</strong> lack of holistic planning; “stuck in the mire of bureaucracy due to professional boundaries.” (Clinical Psychologist)</td>
<td><strong>Sharing of resources and funding:</strong> no evidence</td>
</tr>
</tbody>
</table>
Appendix 16  Risk factors identified by professionals across micro, meso and macro levels

Examples of Micro Level Risks stemming from professional responses

<table>
<thead>
<tr>
<th>Education</th>
<th>Health</th>
<th>Social Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning difficulties</td>
<td>Disorders – e.g. autism</td>
<td>One parent family</td>
</tr>
<tr>
<td>Cognitive ability</td>
<td>Temperament</td>
<td>Poor parenting</td>
</tr>
<tr>
<td>Poor concentration</td>
<td>Displacement</td>
<td>Temperament</td>
</tr>
<tr>
<td>Emotional / behavioural difficulties</td>
<td>Attachment issues</td>
<td>Family / Sibling conflict</td>
</tr>
<tr>
<td>Temperament</td>
<td></td>
<td>Broken homes</td>
</tr>
<tr>
<td>Complex familial relationships</td>
<td></td>
<td></td>
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<tr>
<td>Poor developmental competences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effect of family break up</td>
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</tbody>
</table>

Examples of meso level risk factors stemming from professional responses

<table>
<thead>
<tr>
<th>Education</th>
<th>Health</th>
<th>Social Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difference of culture</td>
<td>Little community support</td>
<td>Deprived neighbourhood</td>
</tr>
<tr>
<td>Gangs and crime</td>
<td>Gang activity</td>
<td>Criminal activity</td>
</tr>
<tr>
<td>Poor educational resources</td>
<td>Council estate accommodation</td>
<td>Low aspirations</td>
</tr>
<tr>
<td>Community fragmentation</td>
<td></td>
<td>Complex neighbourhood</td>
</tr>
<tr>
<td>Negative peer influences</td>
<td></td>
<td>Large families dealing with</td>
</tr>
<tr>
<td>Drugs and substance misuse</td>
<td></td>
<td>lots of issues – socially</td>
</tr>
</tbody>
</table>

Examples of macro level risk factors stemming from professional responses

<table>
<thead>
<tr>
<th>Education</th>
<th>Health</th>
<th>Social Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic poverty - unemployment</td>
<td>Refugee status</td>
<td>Significant socio economic</td>
</tr>
<tr>
<td>Social deprivation</td>
<td>Impoverished lifestyle</td>
<td>disadvantage</td>
</tr>
<tr>
<td></td>
<td>Financial disadvantage</td>
<td>Poverty and unemployment</td>
</tr>
<tr>
<td></td>
<td>Council estate accommodation</td>
<td>Families with economic issues</td>
</tr>
</tbody>
</table>
### Appendix 17 Types of resilience building strategies utilised by key children’s services practitioners professionals and in relation to the four main categories identified from the review of literature (Masten, 1994, Fraser, 2004, and Smokowski, 1998)

<table>
<thead>
<tr>
<th>Non Management tier – Education Practitioners</th>
<th>Non Management tier – Health Practitioners</th>
<th>Non Management tier – Social Care Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pastoral - direct</td>
<td>Exploration of feelings - direct</td>
<td>Academic support – direct</td>
</tr>
<tr>
<td>Counselling - direct</td>
<td>Ensuring his uniqueness is heard - direct</td>
<td>Cognitive Behaviour Therapy - direct</td>
</tr>
<tr>
<td>Academic monitoring \ support - direct</td>
<td>Analyse present situation and aspirations direct</td>
<td>Anger Management - direct</td>
</tr>
<tr>
<td>Self esteem - direct</td>
<td>Crisis counseling - direct</td>
<td>Counselling direct</td>
</tr>
<tr>
<td>Relationship support - direct</td>
<td>Anger management - direct</td>
<td>Building parent relationships and understanding – reducing stressors</td>
</tr>
<tr>
<td>Counselling - direct</td>
<td>Relationship support - direct</td>
<td></td>
</tr>
<tr>
<td>Reading - direct</td>
<td>Counselling -- direct</td>
<td></td>
</tr>
<tr>
<td>Target setting direct</td>
<td>Nurturing areas of interest - direct</td>
<td></td>
</tr>
<tr>
<td>Strategies to deal with bullying direct</td>
<td>Social and relationship focus - direct</td>
<td></td>
</tr>
<tr>
<td>Withdrawal direct</td>
<td>Strategies for social acceptance - direct</td>
<td></td>
</tr>
<tr>
<td>Social skills- direct</td>
<td>Access to services – increasing services /resources</td>
<td></td>
</tr>
<tr>
<td>Social education programmes direct</td>
<td>Reviews and direct intervention – increasing services /processes</td>
<td></td>
</tr>
<tr>
<td>Anger management direct</td>
<td>Statement reviews increasing services /resources</td>
<td></td>
</tr>
<tr>
<td>Home school liaison - direct</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small group work - direct</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talking - direct</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management tier - Education</td>
<td>Management tier - Health</td>
<td>Management tier – Social Care</td>
</tr>
<tr>
<td>Observe for stress indicators \ identification and intervention - direct</td>
<td>Reflective listening, analytical reflection and structured social interaction - direct</td>
<td>Undertake risk assessments develop increasing services and resources</td>
</tr>
<tr>
<td>Webster Stratton reducing ‘stressors’</td>
<td>Webster Stratton - reducing ‘stressors’</td>
<td>develop social skills - direct</td>
</tr>
<tr>
<td>Therapeutic activity direct</td>
<td>Cognitive behaviour therapy direct</td>
<td>Solution Focussed Therapy direct</td>
</tr>
<tr>
<td>Develop social skills direct</td>
<td>activities relating to psychological</td>
<td>In class support - direct</td>
</tr>
<tr>
<td>Model &amp; develop pupil emotional</td>
<td></td>
<td>1:1 in basic skills direct</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Engage parent and child in social</td>
</tr>
<tr>
<td>Intelligences direct</td>
<td>Models direct</td>
<td>Situations - reducing 'stressors'</td>
</tr>
<tr>
<td>----------------------</td>
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</tr>
<tr>
<td>Establish of a safe and secure environment and ethos mobilizing protective processes'</td>
<td>Art psychotherapy direct</td>
<td>Develop positive and trusting relationships - mobilizing protective processes'</td>
</tr>
<tr>
<td>Train staff to identify issues pertaining to child protection. mobilizing protective processes'</td>
<td>Training teachers mobilizing protective processes'</td>
<td>Regular home monitoring visits - increasing services and resources reducing 'stressors' / mobilizing protective processes'</td>
</tr>
<tr>
<td>Building self esteem and confidence - direct</td>
<td>Regular reviews with parents - reducing 'stressors'</td>
<td>Multi-agency meetings increasing services and resources</td>
</tr>
<tr>
<td>Counselling direct</td>
<td>Work with different agencies - networking increasing services and resources</td>
<td>Assessment of need meetings increasing services and resources</td>
</tr>
<tr>
<td>Building self-esteem direct</td>
<td>Promote social interaction direct sign posting to other organisations - increasing services and resources</td>
<td>Develop self-esteem - direct</td>
</tr>
<tr>
<td>Develop relationships mobilizing protective processes'</td>
<td>Parenting courses reducing 'stressors'</td>
<td>Explore issues - direct</td>
</tr>
<tr>
<td>Build social skills direct</td>
<td>Specific therapy for depression and anxiety - direct</td>
<td>Teach life skills - direct</td>
</tr>
<tr>
<td>Teach self-regulation direct</td>
<td>Develop emotional intelligence - direct</td>
<td></td>
</tr>
<tr>
<td>Creating an positive ethos - mobilizing protective processes'</td>
<td>Anger management direct</td>
<td></td>
</tr>
<tr>
<td>Teaching teachers to have a responsibility for developing resilience reducing 'stressors' / mobilizing protective processes'</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>