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Health professionals in multi-disciplinary and multi-agency teams: Changing professional practice

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Abstract
The article draws on an Economic and Social Research Council (ESRC)-funded research project that aimed to investigate the reality behind the rhetoric of ''joined up thinking''. The research project was a qualitative, multi-method study involving three phases, including observation and documentary analysis; interviews; and focus groups around decision making and knowledge sharing. The article reflects on the perspectives and experiences of health professionals and their colleagues in multi-agency teams about the impact of multi-agency teamwork on their professional knowledge and learning, and on their ways of working. Actual and potential conflicts between professionals are explored about models of understanding, about roles, identities, status and power, about information sharing, and around links with other agencies. Dilemmas of team building and of conflicting values and knowledge are exemplified from health professionals' accounts, using theoretical models of ''communities of practice'' and ''activity theory''. The article presents groups of strategies that health professionals and their colleagues in multi-agency, multi-professional teams use to overcome barriers and to strengthen team cohesion. The conclusion reflects on some implications of our findings in theory and practice for professionalism within integrated, multi-professional teams that are building new ways of working.

Keywords: *Multi-agency working, professionalism, knowledge, learning, joined-up practice for children and families*

Introduction

The concept of collaboration and partnership working in children's services is central to the government's philosophy. A policy of multi-agency working acknowledges the inter-relatedness of family needs in the fields of health, social services, law enforcement, child welfare, housing and education, and aims to make the delivery of services more efficient and effective (Salmon, 2004). There are numerous examples of recent government policy in the UK that seeks to put children and their families at the centre of care planning with agencies working together around them to deliver care. There is variation across the four countries in the UK (England, Wales, Scotland and Northern Ireland), but benchmark examples include: in health in the UK the White Paper *Saving Lives: Our Healthier Nation* (Secretary of State for Health, 1999), and in England both the NHS Plan (2000), and the National Service Framework (NSF) for children, young people and maternity services (Department of Health, 2004); in social services in England the White Paper *Modernising Social Services* (Secretary of State for Health, 1998); in criminal justice in the UK the *Crime and Disorder Act*

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(1998); and in day care and education in England both *Meeting the Childcare Challenge* (Department for Education and Skills [DfEE], 1998) and the White Paper *Meeting Special Educational Needs (SEN)*: *A Programme of Action* (DfEE, 1998). Most recently the Children Act (2004) introduces legislation in England and Wales that will insist on multi-agency collaboration.

However, despite the rhetoric of ''evidence-based policy and practice'', this major shift in public policy has been subject to very little theorizing or research. Often professionals have simply been exhorted to initiate multi-agency working with little training or guidance (Anning & Edwards, 1999). Evaluations and critiques of evidence of multi-agency service delivery for children are at formative stages. Examples are Bertram and Pascal's (1999) evaluation of Centres of Excellence modelling ''joined up services'' for families with children under five; Coles' (2000) critique of services for 13- to 19-year-olds; models of inter-agency work in Special Educational Needs provision (Dyson, Lin, & Millward, 1998); evaluation of a multi-agency child mental health team (Worrall-Davies, Cottrell, & Benson, 2004); and the preliminary findings on the government's anti-poverty initiative, Sure Start, for families with children under three (Barnes et al., 2003). Themes emerging from research, evaluations and commentaries on issues arising from the implementation of multi-agency teamwork in England include dilemmas associated with: reconciling different professional beliefs and practices (Easen, Atkins, & Dyson, 2000; Miller & Ahmad, 2000; Freeman, Miller, & Ross, 2002); the complexity of managing workers on different conditions of service and pay scales (Parsons, 1999; Atkinson, Wilkin, Scott, & Kinder, 2001); problems associated with combining funding streams from distinct service budgets (Roaf, 2002); and the need to invest in joint training and professional development (Parsons, 1999).

An example of empirical research is Ovretveit's work (1993) on teams delivering services in adult mental health. He describes four organizational types of ''formal teams'' (fully managed, coordinated, core and extended and joint accountability) and alternative methods of working such as ''network associations''. However, there is little research evidence of how multi-agency teams are changing their structures and ways of working despite the fact that Onyett et al. (1994) find that implementation issues cause most of the difficulties with multi-professional team working.

This article draws on an Economic and Social Research Council (ESRC) funded research project known as MATCh (Multi-Agency Team Work in Services for Children), based in the UK. Five multi-agency teams working with children were involved in the project: a Youth Crime team, a Child Mental Health team, a Special Needs Nursery, a hospital based Neurorehabilitation team and a Child Development team. The project aimed to investigate the reality behind the rhetoric of ''joined up thinking'' and its principal research objective was to explore the perspectives and experiences of professionals concerning the impact of multi-agency teamwork on their professional knowledge, learning, and ways of working, with a view to making recommendations about good practice to both those commissioning multi-agency teams and the professionals working in them. Specifically we identify the impact of multi-agency participation on: professional beliefs; professional roles and identities; knowledge creation, including information-sharing; and activities at the boundaries between teams and agencies. In so doing, we reflect on the complex dilemmas experienced by the health and non-health professionals based in five multi-agency teams delivering services to children and their families. We also draw on the research participants' reflections in interviews and focus groups to identify some strategies the participating teams use for working together to facilitate knowledge exchange and decision-making. Our conclusion summarises the implications of our findings in theory and practice for professionalism within integrated, multi-agency teams.

Theoretical framework

Our research draws on two major theoretical frameworks – ''communities of practice'' (Wenger, 1998) and ''activity theory'' (Engestrom, 1999). In Wenger's (1998) model new knowledge is created in communities of practice by the complementary processes of participation (the daily, situated interactions and shared experiences of members of the community working towards common goals) and reification (the explication of versions of knowledge and rules into representations such as documentation or artefacts).

Practitioners from different disciplines are not routinely expected to justify the conceptual base of their actions or interactions with clients in single agency settings. In a multi-agency team differences potentially ''collide'' as boundaries around specialisms are broken down. At this point, implicit knowledge must often be made explicit. Professionals have to find a common language to make knowledge accessible to their colleagues from other disciplines. To understand these processes, we drew on Engestrom's (1999) Activity Theory model in the field of knowledge creation and exchange. Engestrom's model proposes that conflict is inevitable as tasks are redefined, and re-distributed within changing organizations and teams. To create new knowledge and practice, team members must work through ''expansive learning'' processes of openly articulating differences, exploring alternatives, modelling solutions, examining an agreed model and implementing activities (Engestrom, 2001).

Methods

The research project was a qualitative, multi-method study involving three phases. Phase One comprised observation of team meetings and analysis of documentary evidence about team practice and function. Phase Two consisted of interviews with six members of each team (purposively sampled to obtain a mix of professional groups and seniority) to explore issues arising from analysis of evidence from the meetings and documentation. Team members were also asked to keep diaries of critical incidents involving multi-agency interaction in their work.

Phase Three involved team members in focus groups responding to vignettes around decision making and knowledge sharing which were generated from the critical incident diaries. The interview and focus group material was analysed separately at Phases 2 and 3 using NVivo software.

Evidence was coded using a system grounded in responses and based on the theoretical framework. At Phase 1 Wenger's (1998) constructs of participation and reification guided the focus on the teams' work contexts and systems. At Phase 2 analysis focused on professional knowledge, roles and identities. From Phase 2 to Phase 3 Engestrom's (2001) Activity Theory guided analysis of learning cycles, conflicts and resolutions in service delivery. The interpretative approach involved:

- Interaction of theory development; data generation and analysis;
- Progressive focusing of topics for focus groups through analysis of critical incident diaries (Blaikie, 2000; Mason, 2002; Strauss & Corbin, 1998)

We also held a formative feedback session with representatives from all the five teams. The multi-method approach allowed us to explore the complex interplay of both structural systems related to employment and line management and participants' professional affiliations and personal experiences.

All the five multi-agency teams chosen for the research, (see Figure 1), included health professionals as well as professionals from at least one other agency.

Ethics approval was obtained from the local National Health Service (NHS) research ethics committee. Information sheets were provided to all team members and informed consent obtained prior to interviews and focus groups. Participants were assured of confidentiality. A writing protocol for publications was adopted to protect confidentiality.

Results

Five broad themes emerged from our observation and interview data.
Phases 1 & 2:

- Models of professional practice;
- Roles, identities, status and power;
- Confidentiality and information sharing;
- Relations with external agencies.

Phases 2 & 3:

- Strategies used by teams for resolving dilemmas.

Drawing on these results, we then reach conclusions for theory and practice.

Models of professional practice

Among the professions that work with children and young people there are a wide range of shared and diverse models of knowledge and practice.

Differing core professional models. Different issues emerged in our teams relating to the professionals' use of explanatory models. At the team working with young offenders the

Function and size	Lead sector	Agencies represented in team	Work with	Based at
Youth crime (13 members)	Legal /Police	Health, Social Services, Education, Police/Probation, Voluntary sector	Court personnel, Schools, Social Services, Probationary Services	Independent base
Child Mental Health (11 members)	Social Services	Health, Social Services	Parent training in schools, Primary Care Staff, Voluntary Services	Social Services, Community Base
Special Needs Nursery (11 members)	Voluntary	Health, Voluntary Sector	Social, Educational and Health Services	Independent base
Neurorehabilitation (13 members)	Health	Health, Social Services, Education	Education, Social Services, Voluntary Sector	Hospital
Assessment of child development (14 members)	Health	Health, Social Services	Education, Social Services, Voluntary Services	Hospital

Figure 1. Features of the five multi-agency teams.

dominant explanation for offending behaviour was social exclusion exacerbated by inadequate parenting. However, within that broad model, differences in beliefs among professionals conveyed differing implications about interventions with offenders. The nurse within the team argued that multiple socio-economic disadvantages and/or family circumstances will predispose some young people to mental health problems and a limited resistance to stress, and therefore an increased likelihood to resort to deviant behaviour:

> If they have experienced disadvantage in any shape or form, throughout their younger life and that could be developmentally or financially or physically or emotionally, all those factors will predispose a young person to have mental health issues, or have limited resources to deal with stresses in life.

The nurse specialist was taking the lead in increasing the team's capacity to carry out baseline mental health assessments and conduct anger management sessions in response to growing emphasis on mental health issues from the Youth Justice Board. The team drugs worker also discussed the interaction between social and family-related psychological issues. She suggested that vulnerability to social disadvantage could occur in young people with weakened family support networks. However, other members of the team focused more exclusively on social rather than psychological explanations. A probation officer was convinced that nearly all the youth presenting to the team were there because of socio-economic exclusion, which perhaps reflected the dominant beliefs of the team. He discounted psychiatric/psychological explanatory models:

> Generally from working class backgrounds. Nearly always poorly educated, either excluded from school or dropped out of school . . . 95% of the people I see fit into the deprivation stroke economic exclusion model, I've had maybe one person who's got psychiatric/psychological problems since I've been here . . . the overwhelming bulk of young people we see have very very very similar problems; it's drug use, it's exclusion, so there's no discussion around that.

A team social worker concurred that socio-economic exclusion was the primary cause of offending:

> There's the poverty, there's the deprivation, they're discriminated against because they're young, especially with the girls because of their gender, because they're offenders, because they're drug users.

It appeared that the professionals in multi-agency teams were often challenged to contain and embrace diversity, often within a dominant team model, while not sacrificing those personal beliefs which underpin their own commitment. They were challenged to reflect on which of their beliefs about practice are imbued with core values, and which can be modified through the development of new, shared knowledge within the team.

Differing operational models. There were parallels in the experiences of different professionals moving into new work contexts in teams characterised by unfamiliar operational models. The nurse in the team working with young offenders struggled with the operational model she encountered in the management style at meetings. Health professionals value professional ''autonomy'', and she felt challenged by the management

system that emphasized accountability for example in social services or Youth Justice Boards:

> Definitely intrusive. I felt as though I was being managed for management's sake, and being a community nurse working independently, we manage ourselves very much . . . it is a real challenge for everybody to have to listen to the way the meeting is being managed . . . There might be talk for an hour about some order, I know some of the specialists would feel that does not necessarily affect them, and don't need to be there.

While the nurse was uneasy with the dominant managerial style, which she attributed to a social services-influenced culture, the team were united in their concern that the Youth Justice Board overloaded them with demands, including detailed targets. In the team working with children with emotional and behavioural difficulties and managed by social services, members from diverse backgrounds also thought their autonomy was being restricted by social services organizational procedures, for example through protocols around case documentation.

In one of the health-based teams, the main dilemma of competing operational models arose for the social worker. She believed that some medical consultants in the team environment did not understand her employing agencies' procedures, and that some of the consultants did not facilitate her involvement with the team. For example, the social worker felt that the consultants sometimes blocked referrals to her agency and so ''wouldn't get the benefit of the services'' because they could not see the value of the work she could facilitate.

> Sometimes that is blocked though, I think because there is an inability to recognise the value of that work really.

If some medical professionals' ''model'' of social work leads to disengagement, serious dilemmas can arise for social work professionals if they are the only representative of their agency in a larger team located within a health service environment.

Such marginalized professionals may experience a degree of exclusion from the developing culture of a team. Belonging to a different agency can limit their access to knowledge exchange within the team, which would otherwise enhance the team's understandings about the agency. Accounts of some consultants persisting with technical language, and lacking ''patience'' to clarify meanings, was revealed by a social worker's sense that attitude factors, attributable to differences of professional culture, hinder collaboration:

> I found it very hard to go in to that . . . . . meeting. What is daunting is we don't even speak the same language.

Some of these barriers were linked by the social worker to her sense that health professionals do not all understand the range of available social services. There was is parallel here with the nurse's view in the team working with young offenders that some team members did not understand the scope and boundaries of the Child and Adolescent Mental Health (CAMH) service, and had tended to make blanket referrals rather than engaging with manageable mental health issues themselves. This under-valuing of other services or misunderstanding of other professionals' expertise, might suggest a need for joint training and co-practice.

Roles, identities, status and power

Staff in multi-agency teams face issues concerning the balance between specialist and generalist skills and status, with specialists from different agencies being required to redefine their roles. These dilemmas about status and expertise and the distribution of power and status between different professions also relate to the ''models'' explored above.

Professional status – specialist and generalist roles and identities. Different multi-agency teams position individual members differently as specialists or generalists. The redefinition and redistribution of specialist skills provoked complex responses about core beliefs and identities among health professionals in the teams and also raised issues regarding pay and parity with colleagues in other settings. One specialist nurse in the team working with young offenders resisted management attempts to make her take on generic case roles, arguing ''I don't do any generic work at all, so all the work that I do is around health issues''.

A further challenge for the health professionals was redefining the meaning of ''specialism'' in a policy context where all team members carried out work previously assigned to specialists, such as basic level mental health assessments, and anger management. The pressure of retaining a specialist role was balanced with the challenge of developing the role to fit team and service users' needs. For example the nurse in the youth crime team repeated that:

> Sometimes I have had to reflect on other members of the team taking on things that I might have found to be my role.

Similar concerns preoccupied the speech and occupational therapists in the pre-school nursery, The therapists were increasingly required, as a result of education policy, to work alongside teachers as trainers, sharing assessment and planning in mainstream pre-school settings and coaching education staff and parents to carry out elements of therapy. They expressed concerns about effectiveness and status, and anxiety that redistribution of roles might undermine their specialism, leading to their expertise not being acknowledged within their parent agency (health).

The team working with young people with emotional and behavioural issues recruited professionals from diverse backgrounds but created a new ''generic'' Child and Adolescent Mental Health practitioner professional role, under the organizational umbrella of social services. Most team members viewed this new generic role favourably. Individuals valued possessing shared skills, but drawing on diverse experiences. Role convergence around an emerging professional model implied a primary affiliation to the team rather than different agencies. Gains emphasized by the team clinical leader involved avoiding complex differentials and split loyalties.

> Yes it is a little multi-agency but it's not as multi-agency as some might be and I think that's a very good thing. So the different terms, conditions, pay and the argie bargie over what's the social work role and what's the OT role, we haven't got that.

However, in some cases concern over threats to specialist identity was expressed, for example a health visitor seconded to a multi-agency team office noted:

> There have been a couple of incidents outside work where people have said ''Oh what job are you doing now'' and I have said health visitor, it is not clear what. I

> am not saying I am a psychologist or I am a health visitor working in a Mental Health team. It's ''I am a practitioner'' which is a fairly boring term really. I have been a nurse and a health visitor for a lot of years and taught to suddenly stop being one.

There is a parallel here with the concerns about loss of specialist identity of the nurse at the youth crime team. A further concern was that participation in multi-agency teams, and redefinition of specialist status, might not equip health professionals for career progression.

Most permanent members of the team working with children with emotional and behavioural difficulties, however, highlighted their comfort with the role and identity transitions. While the team supported practitioners in negotiating desired moves away from teaching, social work or nursing, the team ethos implied drawing on past identities as a resource: ''it implies being comfortable with your own past, the stuff you're bringing from the past''.

The redistribution of roles in the health-based teams that were primarily multi-professional/multi-disciplinary, rather than multi-agency teams was more limited but still required complex role divisions. In the team assessing children's development, a health visitor saw herself as primarily supporting parents, with her role being extended in a holistic direction to include counselling. There were examples of teams such as the one for children with accidental injury, where health professionals occupied specialist roles, but with areas of overlap as noted by the occupational therapist:

> I think myself and the physiotherapist do a lot of role blurring together in terms of treating the child as a whole.

Power and status. Although it can be difficult to distinguish between issues relating to power and status and those relating to personality, we perceived some emergent patterns. Respondents discussed several dilemmas where status clashes apparently caused distress. Different professions might set a different value on status differences, and in multi-agency teams this could be a factor in tension between professionals. In a health-based team, for example, heath professionals including nurses and therapists chose not to highlight status issues. The psychologist discounted status issues: ''But in terms of status things, I haven't encountered that yet''.

In contrast the social worker in the same team was very preoccupied with status issues: ''I think the barriers are the status of different professionals''.

The social worker described some consultants as thinking highly of their status, whereas she claimed not to be overawed by their status, being one of the more experienced social workers in the hospital social work team:

> I am not overawed by working with people just because they have got a tall hat on, but a lot of people are, and I think a lot of people with tall hats are overawed by their own status as well. Sometimes people aren't listening to each other in that meeting.

Another social worker in a health-based team, described similar views of medical status and appeared unwilling to put medical consultants on a pedestal. More positively,

through ''working alongside paediatricians'' was contributing to a respect for specialist expertise:

> It's broken down a few barriers, working with paediatricians, they're just another profession to me. I don't feel the need to put them on a pedestal, they're down to earth like everyone else in the team . . . it's having the knowledge of the work they do and working alongside them.

In some teams the majority of professionals were employed by one agency (for example Health) and a small minority by another agency (e.g. Education and Social Services). Some ''minority agency'' members were also part-timers or seconded. A danger was that such ''minority'' members may feel disempowered. One psychologist acknowledged that:

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

Confidentiality/sharing information

One of the key procedural ''fault lines'' along which differences between professions arise in multi-agency teams is around information sharing. A particular issue is the value placed upon and the interpretation of confidentiality. Health professionals are often at the centre of these challenges.

Information sharing and protocols/confidentiality. Issues surrounding information sharing were mentioned by respondents from all of the teams. Concerns were expressed about reconciling conditions for medical confidentiality that restrict access to health databases. For example, at the youth crime team, the social worker felt that there was a cultural difference between health agency and social service norms.

> There's issues around confidentiality, health records, . . . the health worker and the drugs worker have confidential files which don't go on the system so you can't access that information.
> . . . I'm used to working in an arena where we do share things all the time and so to have somebody come in with a very strict confidentiality policy makes it more difficult.

In the team for young people with emotional and behavioural problems funded by social services, the team manager expressed concern that specific health service databases remained inaccessible, whereas in neighbouring teams, which were health funded, this might not be the case. Conversely, the same team had better access to certain Social Services databases than the other health-service funded and managed teams.

Conflicting health, social services and education practices concerning confidentiality crystallized around the design of record-keeping and information sharing procedures. In one team meeting, which the research team observed, the team voiced differing opinions over systems for recording case closures. They then addressed these differences by collaborating to produce new written guidelines for recording and exchanging information, illustrating complementary processes of participation and reification (Wenger, 1998).

Issues of confidentiality are often discussed by professionals in terms of procedural differences between agencies. Underlying this can be concerns over whether families

who are required to give consent to referrals to multi-agency teams realise the far-reaching implications for information dissemination across professional and agency boundaries.

Relations with external agencies

The multi-disciplinary teams in which the health professionals work faced particular challenges in how they relate to agencies external to them. This issue helps to define the boundaries between both organizations and professions.

Compatibility of agencies' agendas and procedures. Teams faced dilemmas arising from different agency agendas and procedures. Some problems of clashing priorities work through the system to affect liaison and service delivery. In one of the health-based teams the occupational therapist described the conflicting pressures affecting discharge of children. On the one side, the hospital system demanded patient throughput, and on the other, agencies such as housing and social services had their own procedures for prioritising resource allocation for housing adaptations. According to the occupational therapist:

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

These system barriers of agencies having agendas and procedures that do not match each others' or those of the teams could have an impact on professionals working at the boundaries, who had to balance the conflicting demands of the agencies and the team. For example the occupational therapist, working alongside the health-based team social worker, had problems with housing not delivering resources for clients' rehabilitation once the child was medically well enough to go home, even though other medical professionals were under pressure to press for discharge to free up beds:

> That became a team problem because myself and the social worker weren't having an impact on the problem and things were being promised by the housing office that weren't coming to fruition. For example, housing did not have a suitable house to adapt for many months, the hospital wanted the child to be out, we needed the beds, but this child couldn't be discharged because she couldn't go home . . . .

This highlights the dilemma of the mismatch service, the agency's procedures with those of the team, for example over the timing of case closures. There was a view that multi-agency teams, such as the youth crime team, which formally and inclusively represent a wide diversity of interests can engage effectively with different stakeholder agency agendas. This was linked to the view that teams need to engage with and understand the structural dynamics of their partner agencies and those partner/stakeholder agencies need to be able to work together at a senior level to support the work of the multi-agency teams interacting directly with clients.

On several occasions, within health-based teams, it was suggested that structural links and interprofessional relations with non-health agencies and professionals could be improved. For example, dilemmas of poor integration with education services were described. There were perceptions that some schools are constrained by target-driven, performance-related agendas which affect their attitude to excluded children, children with special needs, or those with emotional/behavioural issues. How this dilemma can be addressed is of interest

since current policy envisages multi-professional teams including health workers and social workers converging on school settings to work preventatively with children at risk of social exclusion.

Inter-agency boundaries and referrals. A key dilemma concerning inter-agency boundaries and referrals is that teams and agencies set referral or inclusion criteria to gate-keep their own boundaries because of resource limits and work-load concerns as well as in response to core aims. As a result, clients with major needs can fall between the tracks of different services.

Respondents from different teams frequently mentioned barriers over referrals to different agencies. The nurse in the youth crime team recognized that the team's goal to refer young people to CAMH services was frustrated by resource constraints and waiting times within those services. Her role was partly to be a gate-keeper for police, while leading on health strategies within the team (for example baseline mental health assessments, and anger management). Multi-professional CAMH teams meanwhile wrestled with long waiting times for referrals between different tiers of the service, and with tightening definitions of children in need, which restricted them from referring cases on to social services.

With the creation of multi-agency teams, then, boundary disputes are not dispensed with. These boundary disputes shift, the points of tension re-located from where they would be if the multi-agency teams did not exist.

Strategies for resolving dilemmas

Analysis of the focus group discussions at phase 3 alongside respondent interviews from phase 2, indicated three broad groups of strategies that health professionals and their colleagues in multi-agency teams use to strive to overcome barriers and to strengthen team cohesion. At the structural/organizational level transparent lines of communication within and between partner agencies are apparently essential, as is sustained preparatory work with partner agencies and mainstream services in clarifying roles/responsibilities for service delivery in the multi-agency team. Teams cannot function as required if all partner/stakeholder agencies are not in agreement about the objectives for the team. Co-location of professionals in shared buildings, whilst not absolutely necessary, potentially facilitates team development and makes it easier to involve all team members in service planning and other meetings. Planning around the physical location of the team also needs to include strategies for ensuring that part time and seconded members feel included.

At the inter-professional level further work needs to take place to clarify common goals in relation to agreed objectives. Team members with different backgrounds, trainings, explanatory models for understanding service users' issues, and language cannot be expected to just work together effectively from day one. Time needs to be invested in team building activities and in allowing the creation of a shared language in team activities and service delivery. Staff members need to understand, acknowledge and communicate about the impact of changes in roles/responsibilities on professional identities and the implications of these changes in working practices on service users. Teams that function well apparently respect specialist expertise but combine this with a willingness to explore and celebrate professional diversity regardless of status.

Time should be set aside for team-building, for establishing joint activities for members from different agencies, and for developing shared protocols and documentation. Our evidence confirms the literature on teams, which highlight task interdependence, establishment of shared goals and values (Alter & Hage, 1993), and effective communication

(Salmon, 2004); dimensions which have been viewed as facilitators of a shared team climate (West & Anderson, 1996).

Developing such shared understandings in multi-agency teams can only be successful if the partner/ stakeholder agencies have agreed core roles/responsibilities and objectives as described above. Significant amounts of time may be needed for these activities in the early stages of team development but even established teams need to be supported and encouraged to provide ongoing opportunities for training and development for staff undergoing changes in work practices.

Conclusion

Our research focused on how professionals work, communicate, and learn together. ''Joined-up'' working has profound implications for the professionals working in teams, and for the agencies that commission services. In multi-agency team work, professional knowledge boundaries can become blurred and professional identity can be challenged as roles and responsibilities change. Team members may struggle to cope with the disintegration of one version of professional identity before a new version can be built. Moreover, the rapid pace of reform leaves little time for adjustment as teams move (often within tight time scales) from strategic planning to operational implementation, with little time for joint training (Birchall & Hallett, 1995).

In this article we have seen that there are actual and potential conflicts for professionals working in multi-agency teams about models of understanding, about roles, identities, status and power, about information sharing, and around links with other agencies. Whilst complex conflicts and contested definitions persist we have also found that teams have developed ways of working together, through team building activities and joint practice, addressing tensions creatively through their respectful engagement with diversity while developing common team values.

Whilst the teams we worked with tended to express confidence during focus groups in their strategies for resolving dilemmas, some strategies (for example those which prioritized developing positive internal team relations at the expense of restructuring relations with specific agencies) might be conceptualized as avoiding underlying issues. It remains to be seen whether some of the real tensions identified in our research will be resolved by teams using these strategies. The evidence from our analysis of team documents, meetings and interviews also indicated the underpinning importance of structural agreements on stakeholder commitments and objectives. Team members are more likely to deliver on their objectives with sufficient planning and support from partner agencies that established the teams in the first place. These findings are consistent with previous studies which point to enablers of inter-professional collaboration which include *not only* enhancing co-ordination structurally, *but also* establishing a culture of ''commitment'' at strategic and operational levels to overcome professionally differentiated attitudes (Freeman, Miller & Ross, 2002; Harker, Dobel-Ober, Berridge & Sinclair, 2004).

The theoretical models underpinning our research methods have helped us to conceptualize dilemmas and potential openings for resolution for professionals and for teams. Engestrom's model of learning was useful in framing our understanding of how dilemmas might be resolved at systemic levels to support knowledge exchange. We observed evidence of ''expansive'' learning cycles (Engestrom, 2001, p. 151) prior to implementation of new practices. However our evidence suggests that more emphasis might be given in the model to nurturing inter-professional relationships and rituals to sustain professionals' commitment to new ways of working as activity systems collide and merge.

It seems important to conceptualize models of multi-agency team work where tensions between sustaining an emerging team ''community of practice'', as in Wenger's (1998) model) and encountering dissonant professional models (as in Engestrom) are prominent. Such models allowed us to examine the value to professionals of specific joint activities in team meetings, on case-work (participation), and also shared team production of protocols, reports and documentation (reification).

The evidence also suggests that recognizing and responding to shifts in professional identities, featured in Wenger's (1998) model of developing CoPs, are particularly important aspects of developing effective multi-agency team work.

Our research also had inevitable limitations which future studies will want to address. Ideally, we would have wished to explore the views of service users alongside those of professionals and also to have observed interactions with representatives of the stakeholding agencies. The professionals we worked with in this research want to make multi-agency teams work and are demonstrably seeking to build new ways of working even where they face persistent challenges. Professionals highlighted what they had in common, but also were able emphasize that teams thrive on respect for diversity. Their expressed pride in membership of their teams formed an important basis for realising effective ''joined-up'' practice.

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