

A Constructivist Grounded Theory Study of the Decision-Making Processes of
Professionals in a Children's Service, Mixed Multi-disciplinary Assessment Team

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ABSTRACT

Since 2003, Children's Services have sought to promote more consolidated work by professionals of different disciplinary backgrounds who might otherwise follow independent forms of practice. This is believed to enhance efficacy and reduce inequality in providing for vulnerable children (Boddy, Potts, & Statham, 2006; DCSF, 2003). Evidence that this improves child outcomes is mixed, however. Professionals may have difficulties working together effectively, for example Anning, Cottrell, Frost, Green, & Robinson (2006) and Sloper (2004).

This research presents a qualitative study into the decision-making processes of a Children's Services multi-disciplinary team (MDT) of educational, health and social care professionals. The study explores which aspects of the MDT strengthen and undermine collaborative work, and how this influences child assessment outcomes.

The study was exploratory, using Constructivist Grounded Theory (CGT) analysis of the recorded discussions of professionals concerning six preschool child cases. All six children were referred with neurodevelopment difficulties. The transcripts revealed a fragmentary MDT with a singular, medical model approach to practice, which in this particular situation, averted collaborative working.

The established context for the operation of decision-making was in the professionals' referral system, whereby a Child Assessment 'pathway' functioned. Decision-making comprised *System routines, Weighing-up significance, Expediency* including *Centralisation* and *Convenience, Continuation of Function, and Avoidance of Difficulty/Unpleasantness*.

Use of the Autism Diagnostic Observation Schedule (ADOS) cut-off score to diagnose autism spectrum disorders (ASD) was an outcome of the decision-making process. Discussions revealed that once such decisions were made, they remained unchanged. Psychoanalytically

informed concepts (Hollway, 2011) were used in analyses. This enabled a framework of understanding for professionals' work, as well as for promoting organisational development and change.

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CONTENTS

ABSTRACT	2
ACKNOWLEDGEMENTS	4
CONTENTS	5
TABLES	12
FIGURES	13
CHAPTER 1 : INTRODUCTION	14
1.1. PREFACE	14
1.2. A CONTEXT FOR MDT WORK IN CHILDREN’S SERVICES	15
<i>1.2.1. Political Context</i>	<i>15</i>
<i>1.2.2. Child Assessment Services</i>	<i>15</i>
<i>1.2.3. MDT Work</i>	<i>17</i>
<i>1.2.4. Mixed MDT Work</i>	<i>17</i>
<i>1.2.5. Educational Psychologists in MDT Settings</i>	<i>19</i>
1.3. RESEARCHER’S POSITION	20
1.4. RESEARCH ASSESSMENT CENTRE: LOCAL CONTEXT	22
<i>1.4.1. ‘Pathway’ Model</i>	<i>22</i>
<i>1.4.2. Pre-research Engagement</i>	<i>23</i>
<i>1.4.3. Professional Disciplines</i>	<i>24</i>
<i>1.4.4. Research Period Changes</i>	<i>25</i>
<i>1.4.4.1. Practitioner Guidelines</i>	<i>27</i>
<i>1.4.4.2. Referral Patterns and Redefinition</i>	<i>28</i>
1.5. CHAPTER SUMMARY	31
CHAPTER 2 : PRELIMINARY LITERATURE REVIEW	32

2.1. MDTs IN CHILDREN’S SERVICES	32
2.1.1. <i>Practice definitions.....</i>	32
2.1.2. <i>The Views and Experiences of Professionals.....</i>	34
2.1.2.1. <i>MATCh Project</i>	35
2.1.2.2. <i>LIW Project</i>	37
2.1.4. <i>Professional Backgrounds and Child Outcomes</i>	38
2.1.5. <i>Study Formulation I.....</i>	39
2.2. WORKING IN GROUPS.....	40
2.2.1. <i>Organisational Perspectives.....</i>	40
2.2.2. <i>Decision-making.....</i>	41
2.2.2.1. <i>Cognitive Emphasis.....</i>	42
2.2.2.2. <i>Feeling Estimates</i>	44
2.2.3. <i>Group Contexts: A Psychoanalytic Perspective</i>	44
2.2.4. <i>Study Formulation II.....</i>	45
2.3. RESEARCH QUESTIONS	47
2.4. CHAPTER SUMMARY	47
CHAPTER 3 : METHODOLOGY	49
3.1. EPISTEMOLOGY AND ONTOLOGY.....	49
3.1.1. <i>Social Constructivism</i>	50
3.1.2. <i>Psychoanalytically Informed Research.....</i>	51
3.2. RESEARCH PURPOSE.....	52
3.3. RESEARCH STRATEGY	52
3.3.1. <i>Grounded Theory Method.....</i>	53
3.3.2. <i>Constructivist Grounded Theory</i>	53
3.4. RESEARCH SAMPLING	55
3.4.1. <i>Recruitment.....</i>	55
3.4.1.1. <i>Child Subjects.....</i>	56

3.4.1.2. <i>Professional Participants</i>	56
3.5. ETHICAL CONSIDERATIONS	57
3.5.1. <i>Regulatory Approvals</i>	57
3.5.2. <i>Confidentiality</i>	58
3.5.3. <i>Informed Consent</i>	58
3.5.4. <i>Participant Contributions</i>	59
3.6. DATA CAPTURE AND TREATMENT	60
3.6.1. <i>Real-World Research</i>	60
3.6.2. <i>Capture</i>	60
3.6.2.1. <i>Joint Discussions</i>	63
3.6.2.2. <i>Referee</i>	63
3.6.2.3. <i>Initial Visit and Keyworker Role</i>	64
3.6.2.4. <i>Time</i>	64
3.6.3. <i>Data Transcription</i>	64
3.7. RESEARCHER REFLEXIVITY	63
3.8. DATA ANALYSIS	67
3.8.1. <i>Computer Assisted Qualitative Data Analysis Software (CAQDAS)</i>	68
3.8.1.1. <i>Initial 'quick' Codes</i>	70
3.8.1.2. <i>Open Codes</i>	70
3.8.1.3. <i>Focused Codes and Constant Comparison</i>	72
3.8.1.4. <i>Theoretical Codes</i>	74
3.8.2. <i>Memo Writing and Reflexive Note-making</i>	75
3.8.3. <i>Theoretical Sufficiency</i>	77
3.8.3.1. <i>Decreasing Interrogation; Increasing Abstraction</i>	77
3.8.3.2. <i>Theoretical Sampling</i>	78
3.8.3.3. <i>Time in the Field</i>	79
3.8.4. <i>Reliability and Validity</i>	79
3.9. CHAPTER SUMMARY	80

CHAPTER 4 : FINDINGS	82
4.1. THEORETICAL CODE ‘MAPS’	82
4.2. A ‘FRAGMENTARY’ MDT MODEL	88
4.2.1. <i>Child Assessment ‘Pathway’</i>	<i>89</i>
4.3. KEY FINDINGS: ACTIVE PROCESSES	91
4.3.1. <i>Referral System Routines</i>	<i>91</i>
4.3.1.1. <i>Panels</i>	<i>94</i>
4.3.1.1.1. <i>Referrer Status</i>	<i>95</i>
4.3.1.1.2. <i>Family Factors</i>	<i>95</i>
4.3.1.1.3. <i>Pathology</i>	<i>96</i>
4.3.1.2. <i>Initial Visit</i>	<i>97</i>
4.3.1.3. <i>Observation</i>	<i>97</i>
4.3.1.4. <i>Assessment (ADOS)</i>	<i>98</i>
4.3.2. <i>Section Summary</i>	<i>101</i>
4.4. KEY FINDINGS: TALK PATTERNS	101
4.4.1. <i>Individual Contributions</i>	<i>102</i>
4.4.2. <i>Talk Exchanges</i>	<i>105</i>
4.4.3. <i>Section Summary</i>	<i>109</i>
4.5. DECISION-MAKING PROCESSES: REFERRAL SYSTEM.....	110
4.5.1. <i>Expediency.....</i>	<i>110</i>
4.6. DECISION-MAKING PROCESSES: AVOIDANCE FUNCTIONS	114
4.6.1. <i>Mother Position</i>	<i>114</i>
4.6.2. <i>Abandonment</i>	<i>115</i>
4.6.3. <i>Professional Adopted Roles</i>	<i>117</i>
4.7. CHAPTER SUMMARY	122
CHAPTER 5 : DISCUSSION.....	123
5.1. SECONDARY REVIEW OF THE LITERATURE	123

5.1.1. <i>Team as Group</i>	123
5.1.2. <i>Role as Work Behaviour</i>	127
5.1.3. <i>Organisation as System</i>	132
5.1.4. <i>Anxiety Effects</i>	134
5.1.5. <i>Productive Work</i>	136
5.1.6. <i>Summary</i>	137
5.2. THEORETICAL DISCUSSION	137
5.2.1. <i>Summary of the Theoretical Position</i>	138
5.2.2. <i>Decision-making: Context and Processes</i>	142
5.2.2.1. <i>Context</i>	142
5.2.2.1.1. <i>System Processes</i>	143
5.2.2.1.1.1. <i>Weighing-up</i>	144
5.2.2.1.1.2. <i>Convenience and Centralisation</i>	144
5.2.2.1.1.3. <i>Continuation of Function</i>	145
5.2.2.1.2. <i>Avoidance Functions</i>	145
5.2.2.1.2.1. <i>Difficulty and Unpleasantness</i>	145
5.2.3. <i>Child Outcomes</i>	147
5.2.4. <i>MDT Work</i>	147
5.2.4.1. <i>Mixed MDT Configuration</i>	148
5.2.5. <i>Primary Task</i>	151
5.2.6. <i>Working as a Group</i>	152
5.2.6.1. <i>Task Difficulty and Decision Avoidances</i>	154
5.2.6.2. <i>Role Constructions and Professional Position</i>	156
5.2.7. <i>Implications and Summary</i>	158
5.3. RESEARCH VALUE	160
5.3.1. <i>The EP Contribution</i>	160
5.3.1.1. <i>EP as MDT Practitioner</i>	160
5.3.1.2. <i>EP as Researcher</i>	161
5.3.2. <i>Strengths and Limitations of the Study</i>	162

5.3.2.1. <i>Design and Method</i>	162
5.3.2.2. <i>Trustworthiness; Catalytic validity</i>	163
5.3.3. <i>Future research</i>	164
5.4. CONCLUSION	165
REFERENCES	166
APPENDICES	179
7.1. ASSESSMENT CENTRE INFORMATION	179
7.1.1. <i>Referral Form</i>	179
7.1.2. <i>Parent: Forms of Consent</i>	185
7.1.3. <i>Professional: Forms of Consent</i>	189
7.2. SUMMARIES OF LITERATURE REVIEWS	195
7.2.1. <i>Preliminary Search (1): Joint Working in Children’s Services</i>	195
7.2.2. <i>Preliminary Search (2): Working in Groups/Teams</i>	197
7.2.3. <i>Secondary Literature Search</i>	199
7.3. ETHICAL APPROVALS	201
7.3.1. <i>Sponsor and Academic Approval</i>	201
7.3.2. <i>Research Ethics Approval: NHS</i>	202
7.3.2.1. <i>Progress Reviews</i>	205
7.3.3. <i>Local Research and Development Approval: NHS</i>	208
7.4. DATA ANALYSIS SOURCES	210
7.4.1. <i>First, initial ‘quick’ CGT Codes</i>	210
7.4.2. <i>Code Verification Sampling</i>	217
7.4.3. <i>Audit Trail and Time in the Field</i>	222
7.4.4. <i>Reflexive Notes</i>	223
7.4.5. <i>Researcher Memo Sampling</i>	232
7.4.6. <i>Researcher Diagramming</i>	235
7.4.7. <i>Researcher Memos</i>	238

7.5. CAQDAS PROGRAMME ANALYSIS.....	253
7.5.1. <i>Key to Transcription Notations.....</i>	253
7.5.2. <i>MAXQDA CD-ROM</i>	254
7.5.3. <i>MAXQDA Screenshots.....</i>	255
<i>Footnotes</i>	260

TABLES

TABLE 1 DESCRIBED CONTENT OF PROFESSIONAL MEETINGS IN RESPECT OF ALL CENTRE CHILD REFERRALS.....	23
TABLE 2 PREVIEWED, CENTRE PROFESSIONALS' WORK, BEFORE STUDY COMMENCED.....	24
TABLE 3 ASSESSMENT CENTRE, DEMOGRAPHICS FOR UNDER-6 TEAM REFERRALS.....	30
TABLE 4 CAUSAL, EXPLANATORY MODELS FOR CHILD DIFFICULTIES, FROM ANNING ET AL, (2006).....	35
TABLE 5 SUMMATIVE DETAIL TO STUDY CHILD CASES.....	56
TABLE 6 CHILD CASES 'PATHWAY' WITH RELEVANT INVOLVED PROFESSIONALS.....	62
TABLE 7 FIRST, INITIAL 'QUICK' CODES	70
TABLE 8 TEXT SEGMENT, OPEN CODE EXEMPLARS	72
TABLE 9 MAXQDA DATA ARRANGEMENT: TWO TEXT SEGMENT SAMPLES.....	73
TABLE 10 MEMO EXEMPLARS.....	76
TABLE 11 CODE MEMO CONTENT EXEMPLARS.....	77
TABLE 12 KEY TO COLOUR CODES IN THEORETICAL CODE 'MAPS'.....	83
TABLE 13 DEEP-ROLE MATRIX OF ARCHETYPAL ROLE FANTASIES, FROM MOXNES (1998).....	128

FIGURES

FIGURE 1 ASSESSMENT CENTRE '3-STAGE PATHWAY'	22
FIGURE 2 UNDER-6 TEAM USER INFORMATION	26
FIGURE 3 ASSESSMENT CENTRE MODEL OF SERVICE DELIVERY	29
FIGURE 4 ASSESSMENT CENTRE REFERRAL NUMBERS	30
FIGURE 5 MAXQDA SCREENIMAGE OF TOTAL CODES PER CHILD CASE TRANSCRIPTION EVENT	69
FIGURE 6 CODE MAP: DECISION-MAKING - REFERRAL SYSTEM	84
FIGURE 7 CODE MAP: DECISION-MAKING - AVOIDANCE FUNCTIONS	85
FIGURE 8 CODE MAP: ADOPTED ROLES (CONTROLLER, GUARDIAN, PACIFIER)	86
FIGURE 9 CODE MAP: ADOPTED ROLES (BYSTANDERS-ABSENTIAS-ABSCONDERS, MOTHER-FIGURE)	87
FIGURE 10 ASSESSMENT CENTRE 'SIMPLE' PATHWAY	90
FIGURE 11 VENN DIAGRAM: PERSON, ROLE AND SYSTEM, FROM HUTTON (1997)	131
FIGURE 12 DECISION-MAKING: REFERRAL SYSTEM	139
FIGURE 13 DECISION-MAKING: AVOIDANCE FUNCTIONS	141

CHAPTER 1: INTRODUCTION

Political issues and the nature of MDTs in Children's Services are integral to the context of the current study. This chapter introduces the research area, details the participant Assessment Centre and establishes the reflexive position of the Educational Psychologist (EP) researcher.

1.1. PREFACE

The current political context clearly favours integrated professional practice in Children's Services (*Every Child Matters*, DCSF, 2003; *Children's Act*, 2004; *Aiming high for disabled children: better support for families*, DCSF, 2007; *Equity and Excellence: Liberating the NHS*, DH, 2010). Joined-up delivery of services by both public and voluntary organisations is central to the political endeavour for efficacy (Anning, et al., 2006). However, evidence is equivocal whether collaborative service delivery improves child outcomes (Anning, et al., 2006; Frost & Stein, 2009; Leadbetter, 2008) and placing professionals together in teams does not necessarily lead to better practice (Rose, 2009; Sloper, 2004).

The current study on how professionals make decisions in a Children's Services Education, Health and Social Care (EHC; hereafter also referred to as 'mixed') MDT examines what factors might influence joint working practice. The aim is to understand how decision-making affects child outcome by observing how an MDT conducts shared assessments. The study is

underpinned by the principle that research can go some way to supporting more effective and efficient services to improve child outcomes.

1.2. A CONTEXT FOR MDT WORK IN CHILDREN'S SERVICES

1.2.1. Political Context

Professionals in Children's Services have traditionally had their work organised within specific locality teams. Recently, local authorities have reorganised these into Adult or Child Service areas, in response to new policies from the Department of Health (DH) and Department for Children, Schools and Families (DCSF¹), which promote 'inter-agency' or 'joined up' working as a means of enhancing social inclusion (DCSF, 2007; DH, 2010). The *Every Child Matters* (ECM) Green Paper (DCSF, 2003) and the Children Act (UK Government, 2004) promote collaboration across education, criminal justice and health and social services, with the belief that joint work can improve outcomes for children and young people: 'Integrating professionals through multi-disciplinary teams responsible for identifying children at risk, and working with the child and family to ensure services are tailored to their needs' (DCSF, 2003, p. 51). This political position arises largely from the cumulative evidence of critical social service reviews, for example Laming (2003) and DCSF (2009), which drew attention to practice issues when professionals' communications across services were ineffective. However, the evidence regarding whether professionals working together improves child outcomes, remains unclear.

1.2.2. Child Assessment Services

The joint inter-agency approach to professional practice used in the assessment of children with neurodevelopment difficulties, is consistent with the new direction advocated by official bodies

concerned with the diagnosis and prognosis of such children. A health practitioners guide promotes the participation of children (Wood, Turner, & Straw, 2010) and standards and guidance for Child Development Services highlights ‘specialist services for assessment and management of children with disabilities’ in a given locality, provided through ‘the co-ordinated approach of a Child Development Team’ (Evans, Knight-Jones, & Nicholson, 2000, p. 4). The National Autism Plan for Children (NAPC) (Le Couteur & NIASA, 2003) and the National Institute for Health and Care Excellence (NICE) advice for Attention Deficit Hyperactivity Disorder (ADHD) (NICE, 2009) and ASD (NICE, 2011) promote for recognition, referral and diagnosis using MDT, ‘local pathways’ (NICE, 2011, p. 13).

All acknowledge a wide variability of response to children’s difficulties, with the path to diagnosis, support and intervention of conditions varying nationally and depending upon location and individual professional locality structures: ‘the post-code lottery’ (NICE, 2011, p. 196). For example, a Welsh Government review of ASD diagnostic practices reported ‘striking differences evident in organisational structure and processes’ with MDT working that ‘included different configurations of professionals and different organisational procedures across different regions’ (Wales Government, 2010, p. 1).

Variations may reflect a tension between providing a service appropriate to a given location, as a local empowerment model and providing one that, whilst specific to a local area, is consistent with the national view. Such differences may lead to identification of a child’s condition or behaviour in one locality but not in another. Consequently, joined-up practice of professional, public and voluntary organisations has been emphasised, based on the belief that better communication amongst agencies improves both practice and uniformity (Boddy et al., 2006).

1.2.3. MDT work

Children's Services MDT work refers to the joined approach of several disciplines and the outcome and impact of the professional opinions and negotiations of the team members. Evidence of the efficacy of this form of teamwork and its outcomes for children and families, is important to inform development of local service. The Children's Trust pathfinder areas, introduced in 2003 to promote greater integrated working, found mixed evidence for better child outcomes (Bachmann et al., 2009). Review of the efficacy of 'flagship' areas revealed that strategic development and governance was often more advanced than frontline team work; most effective outcomes were seen in more integrated services (O'Brien et al., 2009). Integrated services were associated with lower levels of primary school absence and those with a remit for all vulnerable children rather than children with one specific type of need, had higher child-in-need referrals but lower secondary school absences (O'Brien et al., 2009). Analysis of yearly trends (1997 to 2003) for these 35 English pathfinders, when compared with similar data of the total (N = 150) English local authorities (1998-2004), indicated low-level, positive outcome changes. For example, decreases in annual teenage pregnancy rates or increases in the numbers of looked-after children communicating their view in statutory reviews, were positive trends in all authorities but not significantly better or different in Pathfinder authorities (O'Brien et al., 2009).

1.2.4. Mixed MDT work

In the context of Children's Service assessment, guidelines recommend an MDT approach for the multi-modal assessment of a child's profile of strengths and weaknesses (Boddy et al., 2006; Le Couteur & NIASA, 2003; NICE, 2009, 2011). National ASD guidance proposes that the core group in an MDT should include a paediatrician and/or child and adolescent psychiatrist, speech

and language therapist, occupational therapist and clinical and/or educational psychologist. Access to any one of these when not a member of the core team is preferred (NICE, 2011). Professionals recommended for secondary care pathways of a child's presenting concerns for ADHD include a psychiatrist, paediatrician, educational psychologist, Special Education Needs Co-ordinator (SENCo) and social worker (NICE, 2009).

The disciplinary narratives of EHC professionals might be significant in understanding the joint working practice of MDTs. Professionals involved in this type of assessment work may have different priorities as individuals and might seek to emphasise their particular perspective. Difficulties have been noted when professionals from varied backgrounds use different discourses and draw upon alternative research evidence as the basis for practice (Forbes, 2003). Diverse views can hinder effective joint work practice, with teams becoming 'stuck' and using a lack of time as a reason not to work collaboratively (Sloper, 2004). Negative stereotypes amongst professionals and agencies was detrimental to trust (Sloper, 2004). Despite the notion that joined up working will remedy disjointed practices (DCSF, 2003), the operation of such groups remains problematic (Forbes, 2003; Warmington et al., 2004).

When professionals assess a child with neurodevelopmental difficulties, practice decisions may be guided by individual training, practical experience and expectations about developmental difficulties based on knowledge schemas (Bartolo, 2001). There are two dominant knowledge schemas for what causes childhood disability. A medical model draws upon a biological understanding, and favours a within-child focus for problems (SIGN, 2007; Volkmar, Paul, Klin, & Cohen, 2005). A social model views a child's difficulties as a possible result of contextual and environmental influences related to their lived, social experiences (Bartolo, 2001; Goodley, 2001; Zimmerman & Schunk, 2003). Based on the new guidelines (DCSF, 2003, 2007; DH, 2010; NICE, 2009, 2011), different professions with differing backgrounds and models of knowledge are expected to work collaboratively. Observing professionals during MDT

discussions might provide insight into how the different professional disciplinary perspectives interact.

1.2.5. Educational Psychologists in MDT Settings

Recent investigative reports into the work of EPs in Children's Services Authorities reveal the range and diversity of their practice (AEP, 2008). Whilst EPs traditionally work in schools, these reports promote a view of the EP as a professional who can make a valid contribution to MDT community contexts. The areas surveyed were of EP MDT practice in Sure Start Local Projects (Davis, Gayton, & O'Nions, 2008), fostering and adoption services (Norgate, Trail, & Osborne, 2008) and for Children in Care (Norwich, Richards, & Nash, 2008). The studies concluded that there is scope for EPs to apply their psychological knowledge and skills to the wider range of services and settings derived since ECM (DCSF, 2003) came into being (AEP, 2008). Miller, Gulliford and Stringer (2006) have previously observed that EPs are well placed to manage in a variety of different settings. EPs can often significantly influence decisions in education, care or mental health provisions or placements (Fallon, Woods, & Rooney, 2010) and the role of the EP has also been described as being necessarily fluid, frequently positioned as it is between interconnected systems (Stobie, 2002).

In the next section, the position of the EP researcher in the conduct of the research is described; the motivations for researching these questions and the stance adopted towards are explored (Yardley, 2000).

1.3. RESEARCHER'S POSITION

The research formed part of the requirements for the professional Doctorate in Child and Educational Psychology at The Tavistock and Portman NHS Foundation Trust. Here, attendance of the postgraduate course *Therapeutic Communication with Children* involved regular work-discussion experience: sharing casework with other professionals. The different viewpoints added variety to the group interpretations, and allowed wide-ranging discussion. This sparked curiosity about the reality of the work of MDT professionals since ECM (DCSF, 2003).

The researcher's interest in the area was also the result of professional involvement in a specialist setting for children with severe and complex ASD. Participation coincided with the start of the professional doctorate. Frontline professional practice in mainstream schools and a view of upward trends in children presenting with specific difficulties or delayed development, identified as an autistic spectrum (Waite & Woods, 2007) or hyperactivity 'disorder', added to interest in this topic. The idea of reassuring parents and carers and 'unlocking' possibilities of resource and strategies not otherwise available (Selfe, 2002) were encouraging factors to consider, however there was the concern that a diagnosis of ASD or ADHD might foster particular responses towards a child. Debate continues in the EP profession (Hill, 2013; Traxson 2010). In addition, the 'pressure to diagnose' placed on professionals from anxious parents, 'creates its own momentum' and inherent problems in processes that become 'time-limited, one-off assessments' (Selfe, 2002, p. 336).

Different career perspectives in nursing, Early Years play and development practice, FE education and training and more recent study of psychology and educational psychology also informed the researcher position. The earlier careers used scientific, biological approaches to understand phenomena, with alternative, humanistic and self-organised learning principles and

recognition of play and practical experiences in child learning and development. These perspectives, the professional training and work as an EP and the systemic and psychodynamic insights offered through the Tavistock Clinic, characterise the particular researcher position and interpretation of the study findings.

As an EP, the researcher was interested in developing a better understanding of the field. EPs traditionally prefer qualitative approaches of inquiry, which are considered more accurately to reflect the real world (Robson, 2011). EPs conduct evidence-based research to assist vulnerable children (Crimson, 1999). This reflects professional policy and guidance (BPS, 2005; DCSF, 2007; NICE, 2009, 2011), with expectations that practice is guided by the use of theories derived by research promoting the best evidence-based position (Fox, 2003). Political encouragement for greater joined up working and reports of EPs involved in different spheres of practice (see section 1.2.5, p. 19), furthered this interest in an EP contributing to an MDT. Any aspects of specific professional practice gained from the study could potentially be shared in the profession.

There was no *a priori* hypothesis, but the use of the described EP insights and experiences provided a sensitised approach to the findings (McCreaddie & Payne, 2010). This led to a qualitative methodology, with the researcher adopting an open stance to possible findings emerging from the study (Charmaz, 2006). In the next section, the context of the participating Assessment Centre is described, including the professionals involved, researcher pre-study engagements, and an overview of changes to the Centre during the research period.

1.4. RESEARCH ASSESSMENT CENTRE: LOCAL CONTEXT

The participating Assessment Centre is a relatively new service (since late 2009/early 2010), developed from a National Health Service (NHS) Child Development Centre (CDC) model, in a unitary authority in central England. Its aim is, ‘the provision of multi-disciplinary assessment advice and support for children and their families with significant and complex medical, developmental and/or social needs’².

1.4.1. ‘Pathway’ Model

Initial discussions were held with the Centre Manager and Under-6 Team Lead, providing description of the service delivery and establishing the research opportunity. Provision for child referrals involves a '3-Stage Pathway' of needs-based assessment and intervention. Professionals hold routine multi-agency panel meetings in bi-weekly cycles between Under-6 and Over-6 teams. Discussions are conducted on a case-by-case basis, and based upon information on the referral form. This pathway description is illustrated in Figure 1:



FIGURE 1
REPRESENTATION OF THE ASSESSMENT CENTRE ‘3-STAGE PATHWAY’ USED IN THE CONSIDERATION
OF CHILDREN REFERRED FOR PROFESSIONAL SERVICES

Table 1 illustrates the typical content of the assessment pathway model:

<u>MULTIAGENCY PANEL 1:</u>	<u>MULTIAGENCY PANEL 2:</u>
Initial child case referrals reviewed by a group of professionals according to information submitted via the Centre's referral form and a decision made as to a preferred course of action.	Review of the first referral information and follow-up information since gathered, according to the initial preferred course of action. Professionals then either signpost to alternative services or move a child referral towards a clinical assessment plan (CAP).
<p><u>CAP:</u> This involves a Plan-Do-Review process for the child, as follows:</p> <ul style="list-style-type: none"> i) Allocation of Key Professional and subsequent Professional involvement Plan for the child; ii) Review of Plan through involved professional discussions; iii) Feedback to parents; iv) Professionals' debrief. 	

TABLE 1

DESCRIBED CONTENT OF PROFESSIONAL MEETINGS IN RESPECT OF ALL CENTRE CHILD REFERRALS

1.4.2. Pre-research Engagement

Qualitative methodology requires the researcher to acknowledge their individual influence on the research (Shaw, 2010). Pre-research requirements consist in researchers addressing any relevant technical issues and ambiguities (Cohen, Manion & Morrison, 2007). To enhance an understanding of the professionals' work perspective at the Centre, consent was given for the researcher to observe aspects of practice. This involved accompanying a play-based assessment, two panel meetings and an inter-agency case discussion. Table 2 presents the professionals present at each preview event.

1 PANEL MEETINGS (Two events):

- Centre Manager (Speech and Language Therapist)
- Under-6 Team Lead (EP)
- Assessment Team Manager, Social Care and Disabilities Team (Social Worker)
(absent for the second Panel observation)
- Manager for Specialist Inclusion Teaching Service (Specialist Teacher)
(absent for the second Panel observation)
- Speech and language therapist trainee
- Specialist Teacher *(present in place of the Specialist Inclusion Manager (above) at the second Panel observation)*

2 PLAY-BASED ASSESSMENT (Child, Mother and Grandmother):

- EP
- Family Co-ordinator (Nursery Nurse trained)

3 INTERAGENCY CASE DISCUSSION:

- EP
 - Occupational Therapist
 - Early Years Inclusion worker
 - Trainee Clinical Psychologist
-

TABLE 2
PREVIEWED, CENTRE PROFESSIONALS' WORK BEFORE STUDY COMMENCED

Professionals involved in panel meetings represented the Centre's core team. Others accompanied them according to diary commitments and placement opportunities. Whilst present at these events, the researcher made informal field notes, including details of the session, the nature of professional exchanges and other relevant aspects such as group dynamics, seating or ambiance (Robson, 2011). These reflections upon features of professionals' work contributed towards a reflexive commentary during the study (see Appendix 7.4.4, p. 223).

1.4.3. Professional Disciplines

The Centre recommends that child referrals receive a partnership service from EHC professionals for needs-based assessment and support. It advertises itself as follows:

-
1. For children under 6 years of age, with severe and complex medical and or developmental needs, Education, Health and Children's Social Care services work in partnership with families to provide assessment and support in an integrated way.
 2. For children over 6 presenting with evidence of a possible Autistic Spectrum Disorder the Centre can provide a specific diagnostic assessment.
 3. For all ages of children that we work with, a range of social care services are provided by the Children's Disability Social work team and also for children with learning disabilities and an additional health care need, support can be provided through the learning disability nurses.
-


Professionals involved in this research were from the Under-6 Team. The different professional disciplines involved within this team, included physiotherapy, speech and language therapy, paediatrics, health visiting, occupational therapy, specialist inclusion teaching for Early Years, clinical psychology, psychotherapy, educational psychology and disability and social care.

1.4.4. Research Period Changes

During the course of the study, changes were made at the Centre. Its purpose was redefined and new NHS practitioner guidelines were adopted (NICE, 2011). It evolved to more freely provide information about its services via leaflets, posters and NHS and local authority website links. A downloadable referral form was made available through the site (see Appendix 7.1.1, p. 179), and a poster/leaflet (see Figure 2) outlining the assessment and support users of the Under-6 team might receive.

CENTRE SERVICE - UNDER 6 TEAM

For children with complex medical and developmental needs



Health and Education Partnership Working

INDIVIDUAL TAILOR MADE ASSESSMENT

For children accepted via our multiagency panel, we offer a comprehensive specialist assessment service based on agreed areas of need. This will highlight a child's strengths as well as their difficulties and, consider diagnosis where appropriate.

A NEEDS BASED MANAGEMENT PLAN

This will identify a child's individual needs and, provide suggestions on how to help at home and at school.

TRAINING AND CONSULTATION

We offer a range of programmes prepared and delivered by experienced practitioners. These include workshops for parents and training and support for other professionals, including schools.

SPECIALIST PACKAGES OF INTEGRATED SUPPORT

We provide a range of support and therapeutic work in conjunction with other colleagues, according to needs.

THE UNDER 6 TEAM is a multidisciplinary assessment team of health, education and social care professionals. We will create a unique 'team' based on your child's individual needs.

The team may include: a paediatrician, specialist health visitor, speech and language therapist, occupational therapist, physiotherapist, early years practitioner, educational and child psychologist, psychotherapist, family co-ordinator, social worker, specialist teacher and or an inclusion support practitioner.

Assessment broadly refers to the gathering of information which is used to help inform us in making decisions and planning next steps in relation to a child's individual needs and family support.

There are often a number of different steps, over a period of several weeks or months, which we will agree with you. More detail can be found on the FAQs.

If you have any questions please contact the [redacted] and ask for a member of the Under 6 Team. Helpful information is also available at [redacted]






FIGURE 2

UNDER-6 TEAM ANONYMISED USER INFORMATION AVAILABLE ON-LINE AND IN THE CENTRE WAITING AREA

An overview of how the NICE (2011) guidelines informed Centre practice follows below, including assessment advice, ADOS requirements and parent and child considerations.

1.4.4.1. Practitioner Guidelines

Core elements of assessment are detailed enquiries about a child's home life, education and social care experiences (NICE, 2011). Assessors are recommended to consider 'what information from other sources might be useful as contextual information...how the child functions in different environments such as school and home; social care reports... and information from other agencies' (NICE, 2011, p. 259).

Guidance refers to ADOS on the basis that it is so widely used. This tool provides semi-structured, standard play activities and interview techniques to directly assess features of autism in a child or young person, across three domains of behaviour, as established by the ICD-10³ and DSM-IV-TR⁴: social-communication/reciprocal social interaction, play/imaginative use of materials, and repetitive behaviours (NICE, 2011)⁵.

During assessment, attending to the perspective of the parent is emphasised: 'always take parent' or carers' concerns and, if appropriate, the child's or young person's concerns, about behaviour or development seriously, even if these are not shared by others' (NICE, 2011, p. 8). Parental confidence in a diagnosis increased when an MDT was involved, and parents preferred professionals involved with the care of their child to be present, requesting that their child be seen across various settings, with more individualised professional involvement beyond the clinic (NICE, 2011).⁶

Reference to child interests is alongside the parental view: '...the importance of careful discussion and involvement of the parents, carers and, where appropriate, the child or young person in the process, while keeping the child's or young person's interests central to the decision-making process' (NICE, 2011, p. 55). Legislation states that children and young people have the right for their views, wishes and feelings about decisions made about their lives to be considered (UK Government, 1989, 2004; United Nations, 1999; Wood, et al., 2010). The views of vulnerable children with communication deficits (those who, literally or metaphorically, have

no voice) are often expressed non-verbally using actions, body language, facial expression and demeanour (Ross, 1996).

1.4.4.2. Referral Patterns and Redefinition

During the research period, the Centre redefined their original service description (see page 25) as:

-
1. The Under-6 Team: *for younger children up to 6 years of age, with complex medical and/or developmental needs including difficulties that may indicate the possibility of an Autism Spectrum Disorder.*
 2. The Over-6 Team: *for older children aged 7 years to 18 years with difficulties that indicate the possibility of an Autistic Spectrum Disorder.*
 3. The Children's Disability Team: *a team of social workers working with severely disabled children up to 18 years old. This team provides additional family support, information, care packages, access to short breaks and child protection services.*
-

A model of the professional configuration of the Centre is presented in Figure 3. The central zone (red) indicates professionals with specialised input to MDT assessment; the middle zone (blue) shows professionals with discipline-specific assessment contributions; and the outer zone (green) shows practitioners in universal services that might also contribute specific information.

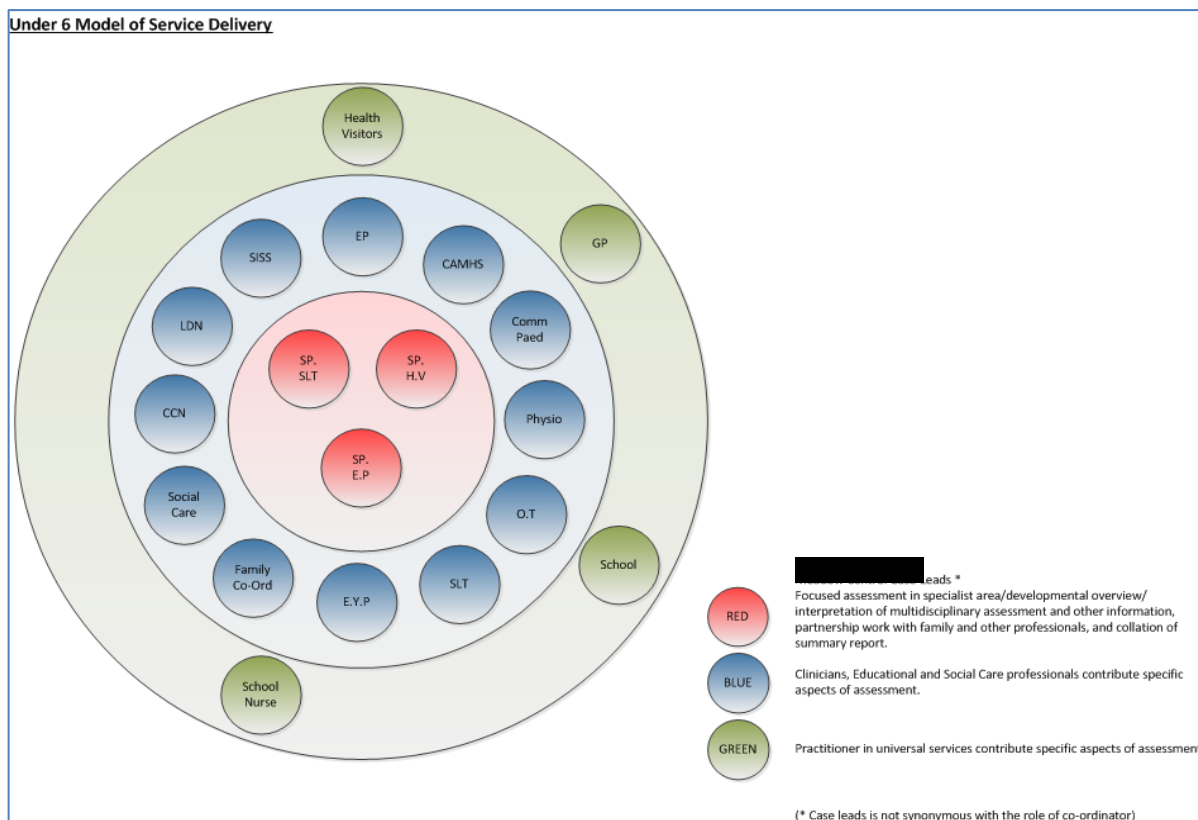


FIGURE 3
ILLUSTRATION TO SHOW ASSESSMENT CENTRE MODEL OF SERVICE DELIVERY

Referral patterns to Under-6 services included overall figures immediately before and since the inception of the Centre (see Figure 4). The number of referrals has increased, particularly of younger children. These demographics of the Centre summarised by the Team Lead, are in Table 3 (p. 30).

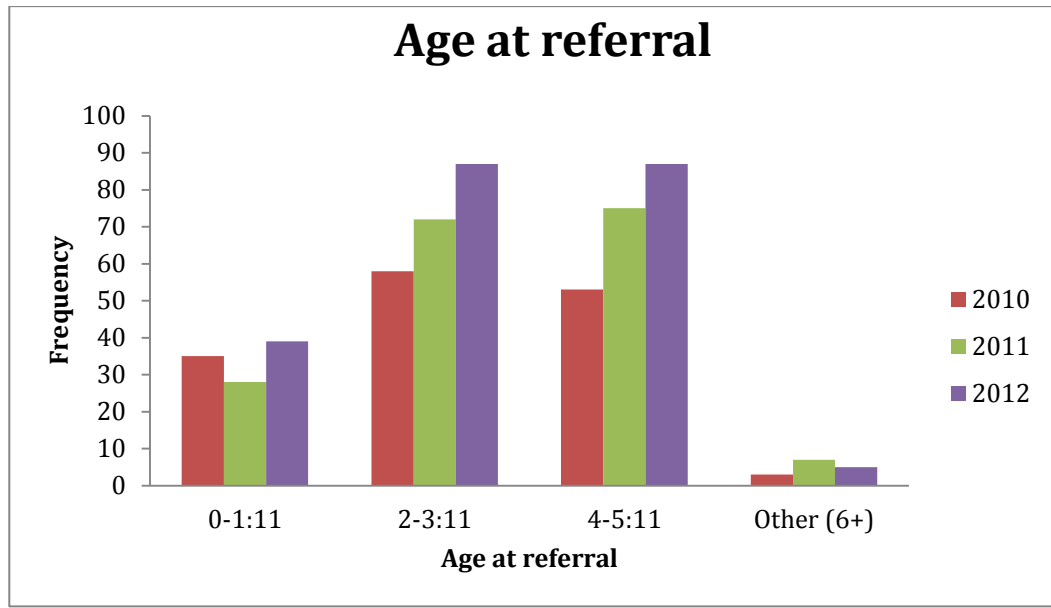


FIGURE 4
CHART TO SHOW THE REPORTED RISE IN ASSESSMENT CENTRE REFERRAL NUMBERS BY DIFFERENT AGE RANGES

- Increasing referral rate to Centre and key partners; At least 1 in 100 children under the age of three years has an autism spectrum disorder (ASD); suspected in 3 in 100.
- The Under 6 team has a 28% increase in referrals accepted 2011-2012.
- The combination of extra referrals and an improved quality of referral information (the percentage of outcomes listed as 'more information requested' has decreased by 3.6%), resulted in an additional 39 referrals being accepted in 2012 compared to in 2011.
- The percentage of referrals accepted has risen from 67.2% in 2009 up to 78.6% in 2012 (6.9% increase).
- Many children referred under the age of 2 are re-referred at a later stage, as developmental concerns become more apparent.
- Approximately 50% of all referrals to the Centre are for children under 6, with identification of developmental concerns at an earlier age (this correlates with a change in Health visitor practice).
- Changing profile: more girls identified at a younger age.
- Recognition of significantly higher rate of psychological distress and anxiety in parents of young children with developmental difficulties. Recognition of higher rate of behavioural issues, which are major contributory factors to distress in

1.5. CHAPTER SUMMARY

In this chapter, key elements of the study were introduced. The political context and official practice recommendations for MDTs in Children's Services were discussed in the context of assessment of children with neurodevelopment difficulties.

The EHC disciplinary narratives were highlighted as individual professionals might use these to frame their understanding of the children's difficulties. The study investigates how interaction of these narratives might contribute to decision-making in joint work teams.

An interpretative, reflexive position was adopted, and the involvement of an EP in the participating MDT explained with the details of the Assessment Centre. Outline of the context to this participating Centre included detail of particular changes realised during the study.

The next chapter provides a preliminary review of research literature for MDT working in Children's Services and generic understanding for team/group influences and decision-making.

CHAPTER 2: PRELIMINARY LITERATURE REVIEW

Consistent with the CGT methodology, a comprehensive literature review was conducted after data collection and analysis (Charmaz, 2006). A preliminary search was also conducted, however, to establish context and avoid duplication (Chiovitti & Piran, 2003; Dunne, 2011). The literature on MDTs in Children's Services was reviewed, as well as empirical studies on decision-making and group work. The review suggested that the current research might advance future practice in this area (Cohen et al., 2007). Study rationale and research questions are discussed.

2.1. MDTs IN CHILDREN'S SERVICES

Literature on Children's Services MDTs since ECM (DCSF, 2003) was included. Studies relevant to EP practice were favoured (see Appendix 7.2.1, p. 195 for search terms, databases and key papers). Findings included MDT definitions, two large-scale projects (Anning et al., 2006; Leadbetter, 2008) describing practitioner views and experiences and one study of decision-making in preschool assessments, which focused on how professional background affects child outcomes (Bartolo, 2001).

2.1.1. Practice definitions

The concept of inter-professionalism is pervasive in the literature, and exerts a considerable influence on the efficacy of joined-up practice. Differences are found in the prefixes used:

multi-, inter-, or trans- (also, collaborative) disciplinary working. ‘Multi-disciplinary’ has been defined as professionals from more than one discipline working alongside each other but independently, concentrating, for example, on the health or educational need for which they are responsible (Orelove, Sobsey & Silverman, 2004). This may lead to overlap. Alternatively, ‘inter-disciplinary’ refers to the sharing of information by professionals: both decide on education and care programmes; however, specific aspects are separately implemented. This contrasts with ‘trans-disciplinary’ (collaborative) work, in which information and skills shared or transferred over any traditional disciplinary boundary by one or two team members in the ‘frontline’, is supported by other consultancy roles (Orelove et al., 2004).

Collaboration is seen a necessary commitment to shared goals and is distinguished by degrees of *collective efficacy* (the team’s own judgment of joint task capability) and *team reasoning* (consideration of actions or outcomes in the team’s best interests, rather than for oneself as an individual; Norwich et al., 2008).

Warmington et al. (2004) prefer the term *agency to discipline* when defining professional difference. *Interagency* is conceptualised as more than one service provision working together beyond informal networking, in a strategic manner at a formal operational level. *Multiagency* implies that more than one agency works with a client, but not necessarily jointly. Joint planning may either prompt work or cause overlap owing to a lack of clear co-ordination (Warmington et al., 2004).

Interagency and multiagency terms are interchangeable. Differences between them are numerical: ‘Inter-agency’ involves two professions, ‘multi-agency’ more than two professional groups (Wilson & Pirrie, 2000). Frost (2005) proposes a hierarchy to align the different permutations of partnership working:

No partnership: *Uncoordinated*, freestanding services

Level 1: *Co-operation* – services work together toward consistent goals and complementary services, whilst maintaining independence

Level 2: *Collaboration* – services plan together and address issues of overlap, duplication and gaps in service provision towards common outcomes

Level 3: *Co-ordination* – services work together in a planned and systematic manner towards shared and agreed upon goals

Level 4: *Merger/Integration* – different services become one organisation to enhance service delivery

Views of stakeholders towards collaboration are a key aspect of the success of joint working (De Bere, 2003). Findings from the literature are reviewed, including two large-scale projects on the perceptions and experiences MDT members have of interagency work.

2.1.2. The Views and Experiences of Professionals

According to the literature, practitioners regard interagency work as beneficial. Professionals report shared values, the desire to achieve a common goal, focusing on the needs of service users, and developing support packages by sharing expertise (McInnes, 2007). However, Hudson argues inter-professional relations are paid greater attention in promoting inter-organisational working and three differences that create particular barriers for professionals: *Identity*, (how professionals understand themselves and their role), *Status* (hierarchies and power distributions) and *discretion and accountability* (how day-to-day discretion is exercised), (2002, pp. 7, 14). Professionals acknowledge risks and challenges associated with integrated working (Anning et al., 2006). A greater reliance on partner organisations is associated with a loss of autonomy of individual agencies, causing them to consider joint work detrimental to their resources and reputation (Anning et al., 2006; Bachmann et al., 2009). It is challenging for diverse team

structures to develop a coherent, shared purpose, not only because of the different principles, priorities and preoccupations inherent in different backgrounds and trainings, but also accountability to an alternate manager may create the illusion of the ability to influence policy, which in reality is not possible (Stokes, 1994).

The practicalities of Children's Services mixed MDT work has been explored in two large-scale research projects: the Multiagency Teamwork for Children's Services (MATCH project) (Anning et al., 2006) and the Learning In and For Interagency Working (LIW) project (Leadbetter, 2008).

2.1.2.1. MATCH Project

MATCH investigated five MDTs in Children's Services in England: youth crime, mental health, a special needs provision for under-fives, neuro-rehabilitation (head injury), and assessment of child development (Anning et al., 2006). The qualitative, multi-method study over three phases allowed documentary and observation evidence to be gathered, with follow-up interviews to explore any subsequent issues. In focus groups, team members responded to vignettes of relevant critical incidents in the context of decision-making and knowledge-sharing. The complex interplay between structural/organisation systems and the personal feelings and affiliations of professionals was revealed. Teams used different explanatory models in approaching cases:

TEAM	DOMINANT EXPLANATORY MODEL	COMPLIMENTARY, SECONDARY MODEL
Young People's team	Family/systemic	Social deprivation
Child Development team	Medical	Social/psychological support
Youth Offending team	Social structural	Individual impact
Nursery team	Individual needs	Holistic approach
Head Injury team	Medical	Social/psychological support

TABLE 4
PREFERRED CAUSAL, EXPLANATORY MODEL FOR CHILD'S DIFFICULTIES HELD BY DIFFERING MATCH PROJECT TEAMS (ANNING ET AL., 2006, P.52)

Of interest were perspectives reported from the child development team (CDT). Here, the starting point for professional practice was medical diagnosis of the child. Parents were viewed as the main client group and were offered medical treatment, practical resources and psychosocial support (Anning et al., 2006).

CDT members maintained professional structure and distinctiveness by having their own management and accountability systems. The team was categorised as core and extended, with joint accountability – the core team fully managed by a Team Lead, with extended members managed by their original agencies (Anning et al., 2006). The core team were health services representatives with a part time (two sessions/week) social worker, distinct from the health practitioners. Voluntary and educational sectors, classed as network associates, were not considered formal team members and remained under their particular professional manager (Anning et al., 2006).

MDT formation thus applies to a range of different joint work arrangements, and its most effective application remains uncertain (Anning et al., 2006). Heavy demands in rethinking roles and switching to different activities and working practices were issues, especially given limited time and resources; ‘joint’ work was in reality ‘parallel’ and anxiety and conflict affected how teams worked together (Anning et al., 2006). Specialisations were sometimes set up against one another; for example, the professional use of jargon to exclude others (Anning et al., 2006). Expectations for more general roles were confusing for professionals in that they disturbed their professional views and expectations of themselves as specialists; this blurring of boundaries resulted in changing roles and feelings of loss (Anning et al., 2006). Drawing on the research team’s reflections in interviews and focus groups, issues over pay and parity, status and expertise were causes of conflict that hindered efficacy (Robinson & Cottrell, 2005).

Reflecting on their experiences whilst conducting the research, the authors referred to recurring, structural and ideological themes of dilemmas faced by mixed MDTs (Anning et al., 2006). It

presents important findings regarding the role of emotion in the process whereby individuals attempt to balance personal convictions with maintaining team function. Further, it emphasises the lack of preparation or training that might better facilitate the changes to practice required for joint working (Anning et al., 2006).

2.1.2.2. LIW Project

Whilst MATCH employed an interview methodology to define and describe what professionals regarded as functional in joint work, the LIW project mapped the inter-professional learning progress of five Children's Services MDTs over an 18-month period. There was similar evidence of 'jealous guarding of particular preserves of practice' (Leadbetter, 2008, p. 206) with professionals having difficulty crossing disciplinary boundaries. However, cyclical, researcher-facilitated workshops opened professionals to alternatives and established greater clarity of teamwork purpose. Professionals were encouraged to focus on the child in the wider context, rather than from a specialist, compartmentalised perspective. This led to collaborative improvements in the MDT (Leadbetter, 2008). This research further predicted that, by better understanding the collaborative processes in team formation and membership (distribution of work and expertise, rule-bending and practitioner improvisation), new professional identities might develop with continued encouragement (Leadbetter, 2006, 2008).

These two studies indicate the difficulties inherent in joint work amongst different agencies. Placing professionals in collaborative groups does not necessarily guarantee shared understanding (Anning et al., 2006; Hughes, 2006). Findings on how Children's Service MDTs work together are relevant when the outcome of their joint work in respect of the child is considered.

2.1.4. Professional Backgrounds and Child Outcomes

Bartolo (2001) and Bartolo, Dockrell and Lunt (2001) studied the decision-making of MDTs based either at a medical (attached to a hospital) or an educational (within a local authority) site. The research examined how professionals from different disciplines perceive and interpret child difficulty and used audio-recordings of child assessments carried out over a half day with the parent, followed by individual professional and family interviews one week later (Bartolo, 2001; Bartolo et al., 2001). Findings indicated that the disciplinary background of a professional influenced decisions about a child: a distinctive approach was adopted in each location. At the medical site, the MDT was health-related, as advocated by a clinical psychologist, paediatrician and speech therapist; at the educational site, an EP, special school advisor and psychotherapist were involved. Professional perspective was associated with different understandings and recommendations for apparently similar child presentations of difficulty (ASD specific; Bartolo, 2001).

In respect of individual child outcomes, the four preschool children in the study had very similar patterns of behaviour (developmental delay, lack of speech, communication and social interaction and stereotypic behaviours). However, the conclusions for each, including diagnosis, varied according to the assessment site attended. At the medical site, professionals used biophysical explanations for the child's disability and consideration whether diagnosis was relevant; the educational professionals focused on behavioural and relationship issues as the cause of the difficulties, concentrating primarily on the child's educational needs (Bartolo, 2001).

At both sites, higher status professionals had influence over decisions, which was perceived to be at the expense of the views of other team members (Bartolo, 2001). Recommendations were for MDT professionals to foster a greater awareness of possible professional bias and a mindfulness

focus on inter-disciplinary components of child assessment. All views might then be considered, and the appropriate support offered to children and families (Bartolo, 2001).

2.1.5. Study Formulation I

In conclusion, verbal discussion protocols and thematic analysis were used to categorise single statements to explain disability and recommendations from professionals (Bartolo, 2001; Bartolo et al., 2001). Verbal protocols are data arising from recorded verbalisations of participants as they conduct tasks either during or immediately after task completion (Swain, 2006). These are considered representative of cognitive processes accessible at that time (Ericsson & Simon, 1993). Bartolo's (2001) research questioned how professionals from different disciplines working as a group perceive and interpret problems in the child, with the choice of method leading to a description of the professionals' spoken perspective. This limited exploration of decision-making processes and the interaction of disciplinary perspectives. The beliefs of professionals at distinct sites, medical or educational, would likely already be closely aligned.

The current study sought to further this research by exploring decision-making in professionals of mixed disciplinary backgrounds (EHC, including an EP practitioner), as they worked jointly in a group. Previous work has demonstrated the anxieties and dilemmas inherent in Children's Service MDT joint work (Anning et al., 2006; Leadbetter, 2006; Sloper, 2004; Warmington et al., 2004). Different professionals use particular disciplinary positions to frame their understanding of child difficulty (Bartolo, 2001; Forbes, 2003) and these viewpoints may coalesce in MDT child assessment contexts (NICE, 2009, 2011). It is thus important to review the existing literature on group working positions.

2.2. WORKING IN GROUPS

The literature search covers aspects of group work. Search terms, databases and key studies are presented in Appendix 7.2.2. (p. 197).

2.2.1. Organisational Perspectives

An organisation is defined as an instrument where an enterprise assigns tasks to roles and roles to individuals and groups (Reed, 2001). Multiple contributions from members of one or more groups to manage complex problems is thought beneficial in that a synergistic team approach assists organisational success; that is, $1+1=3$; organisations are interrelated sets of above- and below-the-surface problems and opportunities, which need to be considered and addressed as whole systems (Allen & Hecht, 2004). There is a rich and influential literature on the social and affective psychology of groups, revealing a human predisposition to work collectively (Hogg & Turner, 1987; Hogg & Williams, 2000). Buchanan and O'Connell (2006) report that even group members with apparently different priorities will act together to achieve a common goal. Field Theory proposes that actions are determined in part by social context, with an underlying premise that a group cannot be understood merely by studying its individuals (Lewin, 1936). Effective groups may produce greater outcomes when compared with individual effort; equally, ineffective groups may be destructive (Bion, 1961; Nitsun, 1996; Schutz, 1958, 1966).

Group cohesion is an important concept in the literature. Cohesion enables a good sense of connection; forces such as attraction, morale and solidarity to the group are relevant to members (Dion, 2000). Well-balanced cohesive groups can manage internal stress, and embrace and derive constructive benefit from conflict, in contrast to over-cohesive groups that stifle individuality, causing over-idealisation and groupthink dynamics (Janis & Mann, 1977; Nitsun, 1996). Friction

as conflict has been characterised as ‘contradictory processes of progression and regression, individuality and belonging, attachment and alienation’ (Nitsun, 1996, p. 45). This suggests that group efforts toward ‘co-operation, integration and growth’ can often be counterbalanced by attempts to ‘separate, abandon and spoil’ (Dorahy & Hamilton, 2009, p. 59). It has been acknowledged that different professional identities may adopt generic work practices in MDTs, leading to task repetition and stifling true collaboration with role duplication (Dorahy & Hamilton, 2009).

These views of group functioning are important when considered as a possible context for MDT decision-making. In the following sections, relevant findings from the decision-making literature are presented. These include evidence for cognitive emphasis and the influence of feeling estimation on decisions. The latter, affective component of group decision practice is discussed from a psychoanalytic perspective.

2.2.2. Decision-making

“Decision” implies the end of deliberation and the beginning of action’ (Buchanan & O’Connell, 2006, p. 33). It has been defined as a choice in a course of action from a set of options with the intent of achieving a goal, from the position of an organisation conducted individually or collectively (Baron, 2008).

Quality of group, collective decisions can depend on how a group is structured, with those dominated by a single individual usually not making the best decisions (Wilson, Timmel, & Miller, 2005). Janis presents a view of human groups that spontaneously adopt structures leading to maladaptive outcomes (Janis & Mann, 1977). Studies of group decisions in naturalistic situations has described groupthink as ‘a mode of thinking that people engage in when they are deeply involved in a cohesive in-group’ (Janis & Mann, 1977, p. 77). Highly cohesive groups

may make quick decisions without properly considering the alternatives, when under pressure by a dominant leader, anxiety or stress (Chapman, 2006).

MDT decisions may emerge from dynamics either of high cohesion or of splitting: certain members might be perceived diametrically by the group or its individuals, as 'good, protective, supportive' or 'bad, hostile and destructive' (Dorahy & Hamilton, 2009, p. 60). To counter decisions arising from such conditions, the 'Narcissistic-We' model was proposed (Dorahy & Hamilton, 2009). This involves balancing decisions driven by 'Me-Me' with decisions made from the perspective of 'We/the team-Client' (2009, p. 61). This model encourages individuals first to think of their position and to review any particular stance they may have, avoiding decisions that might occur from a one-sided perspective, poor communication or jumping to conclusions. This also means considering whether a decision is made with the interests of the client primarily in mind, rather than one's own, or checking whether individual interests have superseded the benefit of the group as a whole (Dorahy & Hamilton, 2009).

Following is a review of significant concepts in the decision-making literature relevant for child psychiatrists and psychologists. Variables that influence decisions, such as cognition, naturalistic enquiry and emotional effects (Galanter & Patel, 2005) are discussed.

2.2.2.1. Cognitive Emphasis

A boundedly rational perspective describes reality as complex and human cognition as limited (March, 1991). Decision-making derives from preference and expectation of consequences (Baron, 2008). Expected utility theory proposes that such decisions are a trade-off between probability of an outcome and its utility or usefulness (Baron, 2008). Where capacity to process enough information and make rational decisions is limited (Tversky & Kahneman, 1974), a tendency to use heuristics or cognitive biases is noted: decisions are guided more by one's past

successes or failures than by the rational analysis of one's current position (Kahneman & Klein, 2009). For example, the availability heuristic results in the frequency of easily recalled events being overestimated, whilst underestimating ordinary or difficult to recall events. This has been noted in health diagnostic decision practice for diseases or injuries with high media attention, which are thought to be more common than they in fact are (Elstein & Schwarz, 2002). Confirmation bias is the selective gathering or interpretation of information or evidence that confirms prior beliefs or expectations. Hindsight bias accounts for one having greater confidence in decisions made according to previous similar circumstances than in making reference to statistical probability data (Nickerson, 1998). For example, despite better accuracy of clinical diagnoses when based on case statistics than clinical judgement, clinicians prefer their own judgements than those derived from statistical data (Nickerson, 1998).

Naturalistic decision-making frameworks describe the cognitively complex processes involved in making choices in demanding circumstances: for example, health professionals making decisions in real-life situations with difficult environmental variables, such as time pressure, diagnoses requests, treating patients under stressful circumstances and without complete information or with an unclear psychopathology. Such variables may adversely affect decisions (Galanter & Patel, 2005). Researchers caution that health professionals might prefer to make judgements based on experience rather than on scientific principle, even though they may not yet have all the necessary information, and therefore risk 'errors of omission, zeroing in on a diagnosis too soon, and not properly considering the alternative hypothesis due to confirmation bias' (Galanter & Patel, 2005, p. 682). These models all describe a decision-making process ultimately cognitive in nature, whereby one strives to make rational choices by sifting through data, however, we are also guided strongly by the feelings we anticipate will follow our choices (Maitlis & Ozcelik, 2004).

2.2.2.2. Feeling Estimates

Damasio (2000) has written extensively of work with brain-damaged patients, demonstrating that in the absence of emotion it is impossible to make decisions. Despite the illusion of reaching a rational decision by considering the reasons for and against, ‘primacy of affect’ means choice is in fact primarily determined by likes and dislikes: ‘It is emotional reactions that categorize the environment for us into safe and dangerous classes of objects and events’ (Zajonc, 1984, p. 122).

Baron notes the significance of emotion states (such as anger, fear, shame, pleasure, happiness) arising from particular causes and effects; decisions may be associated with desired or undesired affects (Baron, 2008). Such feeling states may spread amongst members in a group or organisation by way of emotional contagion, the mechanism of which are shared socially in organisations through a collective affect (Barsade, 2002; Barsade & Gibson, 2007; Maitlis & Ozcelik, 2004). Emotional contagion has been shown to influence the mood in a group and group dynamics, both individually and at the group level (Barsade, 2002).

Contrasting interests of different members and the processes of engagement that might occur in negotiations have been highlighted to bring a political element to decision-making in team situations (Pettigrew, 1973). Imagery of tactical ‘games’, with conflicts, unstable alliances and ‘individualistic manoeuvrings’ constitute a context in which emotion likely plays an important role (Maitlis & Ozcelik, 2004, p. 376).

2.2.3. Group Contexts: A Psychoanalytic Perspective

The affective components of group interactions could illuminate practice in organisations, in which individuals engage only conservatively in learning and change, in order to avoid challenging their existing concepts of self, which are protected by ego-defences and thus likely have some dysfunctional influence (Brown & Starkey, 2000). A psychoanalytic perspective

fosters awareness of emotional undercurrents that might emanate in group practice and proposes conceptualisations of human personality and interactions that might improve the understanding of emotional meanings and individual internal worlds (Billington, 2006; Dennison, McBay, & Shaldon, 2006). In the psychoanalytic literature, Bion's (1961) theory of experiences in groups provides insight into unconscious, emotional influences on individual's behaviours when in groups. His theory is based upon evidence of tension between individuals' wish for togetherness and belonging and their need for independent identities that desire to be separate (Stokes, 1994).

Bion (1961) argues that, within each group, two distinct groups can operate: a work group, manifesting at the level of group performance; and a basic assumption group, in which unconscious defences against anxieties and unpleasantness exist. The work group solves problems or completes tasks of which they are aware and able to define. When functioning optimally, members demonstrate respect for and acceptance of one another (Bion, 1961). There is, however, always opposition to the conscious purpose or task of a group, called the 'unconscious collusion'. This is the basic assumption group, the members of which experience internal, emotional and psychological barriers, impeding their performance on a task. It is usually the case that members are not conscious of these barriers, hence the 'unconscious' and a 'collusion' for reasons of being 'drawn in'. "Basic" refers to the anxieties expressed as primitive and instinctual and "Assumptions" to the fact that the group operates "as if" the (basic) assumption are real, or are implicitly true. In basic assumption groups, time boundaries vanish "as if" they are unlimited (Bion, 1961) and any critical dialogue and/or reflection is avoided or discouraged, resulting in a "breakdown" of the group's efficacy (Stokes, 1994).

2.2.4. Study Formulation II

This preliminary review of group work elucidates the possibility for friction or conflict in such contexts (Dorahy & Hamilton, 2009; Maitlis & Ozcelik, 2004) and function may breakdown

under duress (Bion, 1961; Chapman, 2006). The potential difficulties faced by interagency professionals have been discussed (Anning et al., 2006; Leadbetter, 2006; Sloper, 2004). Research could explore whether such difficulties influence decision-making by Children's Services MDTs and whether such variables impact on outcomes for the child, the focus of the joint work. The current study thus aims to investigate what factors might influence decision-making in groups and whether such factors undermine or strengthen the collaborative work of professionals.

An MDT assessment pathway of mixed disciplines might focus on diagnosis, placement or intervention, with professionals contributing individually according to their disciplinary backgrounds, combined with other viewpoints and contributions in order to make decisions and obtain an outcome with regards to the child. Contributions might see educational assessments focus on learning and/or provision, medical assessments on health needs and/or diagnosis, and social work assessments on the family context and living conditions.

There is a paucity of literature on real-world Children's Services mixed MDT decision-making processes. This research sought to address this gap in the literature. The research consists in a naturalistic study of EHC professionals and the outcomes of their decision-making processes for the child. The participating team was a group of professionals, including an EP who provides assessment and intervention for children with neurodevelopmental difficulties. Their naturalistic dialogues were recorded during discussions, to generate meaning from the active processes of real-life MDT decision-making in child assessment practice. Qualitative methodology allowed different viewpoints and negotiations to be explored as they unfolded amongst specialist professionals contributing to overall team function.

2.3. RESEARCH QUESTIONS

To explore the decision-making of professionals in a mixed MDT and illuminate how this might influence the particular outcomes for the focus child. The research questions include:

1. What are the processes used in the decision-making of professionals in a mixed multi-disciplinary, Children's Services Under-6 assessment team?
2. How does the decision-making of a mixed multi-disciplinary team influence the specific child assessment outcome?

2.4. CHAPTER SUMMARY

In conclusion, this chapter presented a preliminary review of the literature on MDTs in Children's Services and the significant features of decision-making and working in a group.

Professionals working in children's assessment services are now encouraged to make specialist assessment contributions jointly. From the literature, it is evident that they are confronted with anxieties and dilemmas in this endeavour. This may be due to threats to the individual identity of professionals, associated with the experience of crossing into different disciplinary territories. Difficulty might also arise from the experience individuals have reconciling their sense of group

membership in the MDT context, where the literature has highlighted there may be affective, defensive practices from the demands of working in a group.

Based on the existing literature, the aim of the current study was to explore whether the described difficulties of joint working might apply to decision-making practice in a Children's Services MDT and to explore whether this might influence child outcomes.

In the following chapter, the methodology is outlined and discussed.

CHAPTER 3: METHODOLOGY

This chapter describes the researcher's theoretical standpoint towards the research task and the methodological approach taken to carry out the study and address the research aim. Ethical issues, and reliability and validity are considered, and a reflexive commentary from the perspective of an EP researcher is presented. The chapter concludes with description of the analysis of the qualitative data, using CGT (Charmaz, 2006).

3.1. EPISTEMOLOGY AND ONTOLOGY

Assumptions about the nature of reality and how knowledge is obtained underpin any investigative approach (Cohen et al., 2007). The qualitative, naturalistic enquiry used here assumed a relativist ontological position, whereby language was key to generating understanding, 'talk involves the creation or construction of particular accounts of what the world is like' (Edley, 2001, p. 437). Recognising that humans do not view the world objectively, but are actively involved in its construction (Jenner, 2007) meant that capturing the socially situated interchanges of professionals was a valid means of building understanding (Gergen, 1985). This placed the emphasis on purposeful knowledge production through constructing understanding using language as the medium to transmit thoughts and feelings and to structure the experience of MDT assessments (Berger & Luckmann, 1991; Burr, 2003).

Focusing on real-world eventualities included an awareness of how to conceptualise participants and understand the researcher-participant relationship (Carter & Little, 2007). A subjectivist epistemology was valued, as well as the creation of meaning through inter-subjective

relationships (Pidgeon & Henwood, 1997). Association was not value-free and knowledge was a co-construction: the EP-researcher and professional participants influenced each other (Charmaz, 2006).

3.1.1. Social Constructivism

From its roots in sociology, constructionism⁷ is about seeking meaning and interpretation of lived experience, describing how individuals and groups create reality through the significance of dynamic, social interactions in social processes (Burr, 2003).

A social constructivist view emphasises the human mind, meaning-making in relation to social context experiences, but such individual constructive understanding psychological (internal to the individual), rather than just cultural and sociologically influenced (Crotty, 2003). This suggests that humans become persons when they engage in social encounters with ‘selfhood’ an aspect of social ‘positioning’, ‘a conception of agency that acknowledges both the constructive force of discourse at a societal level as well as the capacity of the person to take up positions for their own purposes’ (Burr, 2003, p. 188). Social positioning argues that human activity is driven to prefer individual versions of events over others, with those more ‘powerful’ having a greater effect in establishing and maintaining their own versions (Andrews, 2012; Burr, 2003).

Hollway (2011), though, questions this form of individuality when apparently only understood in the context of what is spoken (Burr, 2003). The significance of individual affect and embodied experiences, not necessarily rendered into language, is arguably unaccounted for in social constructivist understanding (Hollway, 2011). A more subjective individuality recognises desires, hopes, wishes and fantasies, otherwise overlooked by ‘all is text’ claims of exact social constructionism (Burr, 2003; Hollway, 2011). Here, psychoanalytic thinking can ‘detect the vulnerability inherent in the desire for things one could not control, the consequent anxiety and the use of unconscious defences against anxiety such as splitting off anxiety-provoking parts,

imaginatively lodging these in others through projection' (Hollway, 2011, p. 6). Psychoanalytic concepts create further meaning for possible shortcomings to explain the subjectivity of 'self' and agency within a social constructivist paradigm.

3.1.2. Psychoanalytically Informed Research

Psychoanalytic theory and technique reflects progress from single-case examinations and knowledge gained through clinical experience rather than formal research (Anderson, 2006). Methods are historically founded on the subjective, affective experiences of the psychoanalyst, understanding the client in the continuous dynamic exchange of relational feelings or ideas, of which the client is not necessarily aware (Hollway & Jefferson, 2013; Rustin, 2003). Using psychoanalytic concepts outside the consulting room, Parker (2002) has argued that although not universally true, psychoanalysis has become effective as a way of talking about ourselves. He recommends avoidance for it as a privileged system of knowledge, which 'comes from the outside to unlock secrets of culture', but instead as one embedded in the culture as a tool and a result of critical inquiry (Parker, 2002, p. 2).

In research, psychoanalytically informed analysis has, for example, been used to better explain the realities of hospitalised and distressed children (Hollway, 2011) and the influences of media representations in teenage girls' psychosexual development (Walkerdine, 1991). Dialogic repression is contrasted with Freud's imagined repression as an inner psychic process, by conceptualising it as an everyday language activity: language use can be fundamentally both expressive and repressive (Billig, 2006). Klein's paranoid-schizoid and depressive positions, have moved away from earlier Freudian drive theory towards an emphasis on intersubjective dynamics (Hollway, 2011).

The clinical tradition of reflexivity, whereby the psychoanalyst has an emotional awareness of their response to the client – the countertransference – also suggests how researchers might

attempt a reflexive stance towards their research (Parker, 2002). Hollway (2011) recommends psychoanalytic “sensitivity” through the adoption of ‘psychoanalytically informed’ understanding in research enquiry (p. 9). The researcher adopted a psychoanalytically-informed approach to interpret the findings in theoretical analysis.

3.2. RESEARCH PURPOSE

The aim of this research was a better appreciation of the field of Children’s Services mixed MDT professional practice in a child assessment context. The researcher used qualitative, exploratory methods to investigate the processes used by a single MDT as its professionals made joint decisions in assessments of children with neurodevelopmental difficulties.

Capturing the daily work discussions of MDT members might be considered a valid representation of the decision-making processes involved and possibly provide an explanation of the outcome in respect of the child. CGT as a rigorous set of systematic strategies (Charmaz, 2006) was employed for its potential by the researcher to make sense of the language and discourse adopted by professionals in everyday working practice (Bryant & Charmaz, 2007).

3.3. RESEARCH STRATEGY

Research strategy and operation should be consistent with the study objective and the behaviours to be examined (Cohen et al., 2007). CGT allows close, detailed inspection of data and therefore

findings ‘grounded’ in what actually took place in specific case discussions. Alternative qualitative methods might compromise such theoretical sensitivity (Charmaz, 2006).

3.3.1. Grounded Theory Method

CGT is a contemporary revision of Glaser and Strauss’s (1968) original Grounded Theory (GT), where a reflexive stance toward the research process and its products considers how theories evolve from the context in which they occur (Charmaz, 2006). Whilst basic GT procedures are universal (coding, memo writing, sampling toward theory development and comparative methods), revisions moving it away from its positivist origins (Charmaz, 2006) are seen mainly in the creative detail of coding and theoretical description (Charmaz, 2007).

As a ‘perspective based methodology’ GT can be adopted by ‘any epistemological perspective that is appropriate to the data and the ontological stance of the researcher’ (Holton, 2009, p. 269). This has led to contested issues over different approaches (Bryant & Charmaz, 2007; Charmaz, 2006; Clarke, 2005; Glaser, 2012). Mills, Bonner and Francis (2006) argue variations co-exist along a methodological spiral, with traditional (Glaser, 2007) and evolved (Strauss & Corbin, 1998) positions, contrasted from constructivist approaches (Charmaz, 2006). From its described roots in pragmatist philosophy and symbolic interactionism, note is made that GT always had a constructivist flavour (Charmaz, 2006; Clarke, 2005; Mills, et al., 2006).

3.3.2. Constructivist Grounded Theory

Traditional GT objectivism (Glaser, 2007) focuses on ‘attending to data as real in and of itself and not to the processes of their production’ (Charmaz, 2006, p. 131). By contrast, ‘a constructivist would emphasise eliciting the participant’s definitions of terms, situations, and events and try to tap his or her assumptions, implicit meanings and tacit rules’ (Charmaz, 2006,

p. 32). This actively repositions a researcher as the author of reconstructed experiences and meanings (Mills et al., 2006).

The epistemology behind the approach is relativist, with knowledge socially produced and constructed and the researcher possessing a particular understanding a singular view among many (Charmaz, 2006). Whereas traditional GT seeks to identify and conceptualise a core concern, CGT presents a more diffuse theoretical product, not necessarily revolving around a core category and in keeping with the ontological relativism of multiple realities (Martin, 2006). Its strength lies in ‘what’ rather than ‘why’ questions of data, generating an explanation of what is actually happening rather than a description of what should be going on (Charmaz, 2006; Mills et al., 2006). It works on the premise that what is “real” is problematic, as analyses are interpretive (Charmaz, 2006), paying close attention to language and action and how experience is constituted and structures enacted (Charmaz, 2007). The iterative process of data collection and analysis inform and guide each other, with theory generated from the interplay and the researcher developing conceptualisations (Charmaz, 2006).

Charmaz promotes abduction to look at ‘all possible theoretical explanations for the data’ (2006, p. 188) and in moving away from the empiricist roots of GT, contemporary methods make use of ‘absences, silences, hidden positions and structural discourses’ that might emerge (Oliver, 2012, p. 382). ‘Naturally occurring’ data (as opposed to that derived, for example, from interview protocols) is the mainstay of discursive psychology (Wiggins & Potter, 2008) and a discursive GT has been used previously to attend to specific discourses arising from particular phenomena (McCreddie & Payne, 2010). Here, a discursive approach combined with CGT demonstrated the spontaneity and interactive quality of humour in clinical nurse-patient interactions through bringing potentially under-developed symbolic interaction views of language to the surface (McCreddie & Payne, 2010).

Such a perspective could maintain an authentic experience of the professionals' discussions, retain their social reality in textual form, and support emergence of significant language categories, in or alongside the situated active processes from the analysis. With a remit to capture naturally-occurring discussion processes in MDT assessments, this was a valid technique to represent the professionals' talk exchanges. Hence, in this study the researcher used CGT analysis of data transcribed using a naturalised text presentation, enabling simultaneous attention to processes, actions and influential language attributes.

In the following section, the sample is described.

3.4. RESEARCH SAMPLING

In any valid CGT study, a wide enough range of people should be sampled to support the required description and explanation of the topic being investigated (Yardley, 2000).

3.4.1. Recruitment

It was necessary to involve a professional team with members who were willing, knowledgeable and in a position to contribute (Cohen et al., 2007). In addition, for insight into the role of an EP in this context, it was necessary to recruit from services with an EP practitioner. The researcher approached three Local Authority Principle Educational Psychologists with EPs known in this position; one was interested in participating. This Children's Service team formed the professional research participants. Six individual child cases referred to the Assessment Centre were the subject of their discussions. Clarity of the participant and subjects' respective positions in the research follows below.

3.4.1.1. Child Subjects

The child cases were a purposive sample of Centre referrals. Whilst the nature of a child's difficulty was specified neurodevelopmental and their age as less than six, the researcher was unable to influence selection of particular children. For confidentiality reasons, reference to these individual child cases is numerical: CHR01:CHR06. Table 5, provides the gender and age of each child from entry to discharge, with the final decision outcome after assessment completion.

GENDER	AGE AT REFERRAL	OUTCOME	AGE AT DISCHARGE (TIME IN SYSTEM)
CHR01 Male	5-years 10-months	'Underlying diagnosis of ADHD' Prescribed medication	6-years, 4-months (6-months)
CHR02 Male	1-year 7-months	'Working diagnosis of ASD'; Review in 12-months At 12-month Review: Diagnosis of autism spectrum disorder	2-years, 1-months (8-months) 3-years, 2-months (13-months)
CHR03 Female	4-years 0-months	Diagnosis of Autism	4-years, 7-months (7-months)
CHR04 Male	2-years 3-months	Diagnosis of Autism	2-years, 9-months (6-months)
CHR05 Male	1-year 10-months	Diagnosis of Autism	2-years, 7-months (9-months)
CHR06 Male	3-years 9-months	Significant language difficulties	4-years, 7-months (11-months)

TABLE 5

**SUMMATIVE INFORMATION FOR EACH CHILD CASE, WITH AGE AT REFERRAL AND DISCHARGE, AND
FINAL ASSESSMENT DECISION OUTCOME**

3.4.1.2. Professional Participants

The Assessment Centre makes known its professional team as 'multi-disciplinary', comprising the three EHC specialist viewpoints. Following parental consent, professionals involved in the assessment of the six children were the Centre Manager (Speech and Language Therapist, SLT), the Under-6 Team Lead (Educational Psychologist, EP), the Head of Inclusion Support Services

(SISS), (Teacher, M), a Paediatrician (Paed), a specialist Health Visitor (SpHV) and three teachers from the SISS team (TCHR). In addition, there were two National Nursery Examination Board (NNEB) trained practitioners, one in the role of Family Co-ordinator (FamCo) (who was not actually a recorded contributor) and an Early Years Support Practitioner (EYPrac). There was also an assistant teacher of SISS and a Speech and Language Therapy student (on placement at the time of the study, SaLTee).

3.5. ETHICAL CONSIDERATIONS

The study was located in a sensitive context with feelings of distress possible and findings potentially undesirable to parents or professionals (Cohen et al., 2007). There were sensitivities inherent to conducting research with human subjects, both adult and child (albeit the latter indirectly). Considerations included issues of consent, anonymity and confidentiality, participant rights to withdraw, data storage and handling, and the benefits and risks of the research.

3.5.1. Regulatory Approvals

Regulatory approvals were relevant and the NHS Integrated Research Application System followed, including Research Ethics Committees and Research and Development Consortia approvals. As insurers and ethical ‘gatekeepers’ of the research (Cohen et al., 2007), these bodies were updated as the study progressed (see Appendix 7.3, pp. 201-209).

The research complied with the British Psychological Society Code of Ethics and Conduct (BPS, 2005) and Standards of Conduct, Performance and Ethics for Practitioner Psychologists (HPC, 2008). Consideration was given to a study of ethical issues for EPs engaged in research (Fox &

Rendall, 2002) and reference was made to *Guidance for Researchers and Reviewers* (NHS, 2009). In the following sections, consent and confidentiality forms to promote participants' protection and confidence, and significant in meeting the above approvals processes, are discussed.

3.5.2. Confidentiality

It was important to address issues of confidentiality and security, both to protect participants' rights and to maximise trust between researcher and participants (Cohen et al., 2007). Following Data Protection policies included clarifying the extent of personal information required and the systems for storing data. Care was taken to remove identifying, personal features of participants during transcription and write-up phases. Parents and professionals were assured that their information would not be traceable back to any individual. This was especially relevant for a single team's involvement with a specific, small number of children.

3.5.3. Informed Consent

Informed consent, as 'procedures in which individuals choose whether to participate in an investigation after being informed of facts that would be likely to influence their decisions' involves four elements: competence, voluntarism, full information and comprehension (Diener & Crandall, 1978, p. 57).

Child consent was sought through the parent 'advocacy' role (Fine & Sandstrom, 1988). Parents in the initial stages of accepting Centre services gave informed consent for recordings of professionals' discussions of their child to be part of the study. Professionals approached parents whom they considered would not be caused undue distress by this additional aspect to their child's assessment. It was emphasised that a decision to participate, or not, would not affect the

child's services at the Centre and that there would be no direct effect for parents or children, as recordings concerned only professional participants.

The researcher presented detail of the study to Centre professionals after a routine staff meeting, by arrangement with the Centre Manager, summarising the aims and background. Professionals recorded as part of the study provided signed consent before data gathering commenced. Parents and participants could opt out of the study at any stage, affecting neither the service received, nor the position of professionals at the Centre. (All relevant forms to obtain informed signed consent are in Appendix 7.1.2. and 7.1.3, pp. 185-194).

3.5.4. Participant Contributions

One aspect of research recruitment is the extent to which incentive to participate is apparent (Cohen, et al., 2007). In this case, none of the professionals, parents or children would benefit directly. The hope, through contribution to the field of professional assessment practices, was benefit for future children in the same position. The possibility of professional contribution to the growing evidence base of what works in assessment services was suggested as an advantage to mitigate for any inconvenience.

The researcher completed all study administration and management in order to minimise disruption. Recordings were made minimally different from usual routine. Professionals switched recording devices on and off at the start and end of the relevant discussions, briefly introduced themselves by role, and, where relevant, stated the date and child under discussion.

By these means and by understanding potential sensitivities, the researcher maintained transparency of detail and purpose in study (Yardley, 2000) and a heightened level of discretion and confidentiality throughout its conduct.

3.6. DATA CAPTURE AND TREATMENT

3.6.1. Real-World Research

A significant element of qualitative studies are consideration of the particular context and extent of important patterns and meanings that emerge from the researcher and participants inter-relationship (Yardley, 2000). The researcher was aware of potential sensitivities in the area and maintained an open dialogue with the professional team. This included pre-research engagement visits and close briefings about the research focus. Initial recording opportunities were missed⁸, however, and the time required for approval and consent quite possibly confounded early goodwill.

During researcher visits to the Centre, professionals held impromptu conversations about child referrals (in the staffroom, kitchen area, at their desks) and discussion included arrangements for their capture. When the study was underway, professionals highlighted it was 'nigh impossible' to actually make these *ad hoc* recordings. In pre-research discussion, the Centre Manager and Under-6 Team Lead indicated the MDT joint discussion aspects of professionals work together. The capture of panel meetings appeared a natural occurrence, although a recording device on the table would have held some unfamiliarity. Joint discussions following panel involved a limited range of different disciplinary perspectives (see Table 6, p. 62). The researcher was aware of the need to maintain study momentum, and to be mindful of encouraging and promoting data collection and keeping a flexible position for opportunities that arose.

3.6.2. Capture

Notwithstanding, audio recordings of professional discussions relevant for individual child cases were captured as the children 'moved' through the Centre's '3-Stage Pathway' (see Figure 1, p.

22). Dialogues were recorded with a hand-held digital recorder. Two were provided, to avoid missing opportunities if recording events converged and to allow flexibility to record professionals' discussions if they occurred elsewhere (for example, in other locations, such as nursery schools). All recordings actually took place at the Centre.

The first child case, CHR01, moved through the 'pathway' with no captured discussions and therefore no transcription data.

19 events were recorded, relevant to five child cases (CHR02, CHR03, CHR04, CHR05 and CHR06). Table 6 (p. 62) presents a summary of how each assessment progressed with the relevant professionals, the amount of time spent on each recorded session, and the child's age in years and months at the time of each event, from entry and up to their discharge.

CHILD CASE [GENDER; AGE]	REFERRAL	PANEL1	INITIAL VISIT	PANEL2	(ADDITIONAL) PANEL3	PRE- ASSESSMENT DISCUSSION	PRE-ASSESSMENT DISCUSSION2	CENTRE ASSESSMENT (ADOS) LED BY KEYWORKER	POST- ASSESSMENT DISCUSSION	(SUMMARY)
CHR01 [Boy; 5y 10ms]	Paed.	nd EP	EYPrac	nrd EP. M.		nrd		SpHV	nrd	
CHR02 [Boy; 1y 7ms]	(ExT)SaLT	EP. SLT. TCHR_1. 6-mins 1y 8m	FamCo.	EP. SLT. M. TCHR_2. 5-mins 1y 10m				SpHV.	nrd	SpHV. 6-mins & 1½ mins 2y 1m & 3y 2m
CHR03 [Girl; 4y 0m]	(ExT)HV.	nd EP	EYPrac.	EP. SLT. M. 6-mins 4y 2ms	SLT. TCHR_4. 3-mins 4y 3ms			EP.	EP. EYPrac. 41-mins 4y 7ms	
CHR04 [Boy; 2ys 3ms]	TCHR_1.	EP. SLT. M. TCHR_2. 3-mins 2y 3m	M.	SLT. TCHR_4. 2-mins 2y 4m			SpHV. Paed. 4-mins 2y 9m	SpHV.	SpHV. Paed. 7½-mins 2y 9m	
CHR05 [Boy; 1yr 10ms]	Paed.	EP. SLT. M. TCHR_2. 3-mins 1y 11m	FamCo.	nd EP.			SpHV. TCHR_7. 8½-mins 2y 4m	SpHV. TCHR_7. SaLTee 15-mins 2y 7m	SpHV.	SpHV. TCHR_7. SaLTee 26-mins 2y 7m
CHR06 [Boy; 3yrs 9ms]	GP.	EP. SLT. 6-mins 3y 9m	M.	EP. SLT. M. 5-mins 3y 11m	EP. SLT. M. 4-mins 4y 2m		SpHV. TCHR_1. 5-mins 4y 7m	SpHV.	SpHV. TCHR_1. 30-mins 4y 2m	

TABLE 6

CHILD CASES 'PATHWAY' WITH RELEVANT INVOLVED PROFESSIONALS AND SPECIFIC CAPTURED PROFESSIONAL SESSIONS, THE TIME FOR THESE IN MINUTES AND THE CHILD'S AGE AT EACH GIVEN EVENT

Key: **nd** = no data (MDT discussion not held). **nrd** = no recorded data (discussion held; recording missed). 1y 18m = child's age, years/ months

SLT = Clinical Lead and Centre Manager, Speech and Language Therapist. **EP** = Team Lead, Under-6Assessments, Educational Psychologist. **SpHV** = Specialist Health Visitor.

M = Manager Specialist Inclusion Support, Under-6Service (SISS), Specialist Teacher.

EYPrac = Early Years Practitioner, Nursery Nurse (NNEB). **FamCo** = Family Co-ordinator, Nursery Nurse (NNEB)

Paed = Paediatrician. **TCHR_1./ TCHR_2./ TCHR_4.** = (Qualified) Teacher (SISS). **TCHR_7** = (Teacher Assistant) Teacher (SISS). **SaLTee** = Speech & Language Therapy student

GP = General Practitioner. **(ExT)HV/ (ExT)SaLT** = Health Visitor/ Speech & Language Therapist, (external of Assessment Centre team).

3.6.2.1. Joint Discussions

Missed opportunities for recording discussions concerning CHR02 meant the Keyworker (SpHV) provided two verbal summaries of essential detail instead. The first was used as a transcription event and the second (available in the data set), although not directly used, as new codes were not evident, provided the conclusions to this child's full assessment.

A single professional concluded the review and decision-making for CHR01 and CHR03's Panel 1, and CHR05's Panel 2 process, with therefore no discussions recorded.

For cases CHR03 and CHR06, professionals held an extra Panel 3 discussion related to the wait time for Keyworker allocation. An additional pre-assessment discussion concerned CHR05 due to parent/child non-attendance of the first offered appointment.

Dyad discussion events occurred for CHR01's Panel 2 (not captured), CHR03's Panel 3, CHR04's Panel 2 and CHR06's Panel 1.

In all other events, there were three or four professionals involved. Panel meetings took place with any one, or all, members of the 'core' Centre team: the Centre Manager (SLT), the Team Lead for Under-6 assessments (EP) and the Manager for SISS (M).

3.6.2.2. Referee

Professionals' known to the Centre team (paediatricians and a specialist teacher (SISS)) referred CHR01, CHR04 and CHR05. Professionals external to the team, a speech and language therapist and a health visitor, referred CHR02 and CHR03. CHR06 was referred by a General Practitioner (GP). In all instances, the referee indicated the parent requested the Centre referral.

3.6.2.3. Initial Visit and Keyworker Role

For all child cases, the FamCo, the EYPrac or the M (SISS) conducted the Initial (home) Visit, between panels. The captured events were of professionals' dialogues only (as befitted the study purpose) and did not include any sessions professionals held with child and parent. Therefore, recording of the Initial Visits and direct child assessments (ADOS) did not occur.

The Keyworker allocated for CHR03 was the EP. For all other child cases, the Centre SpHV acted in the Keyworker role.

3.6.2.4. Time

The length of the discussions was recorded in minutes. The average time taken to discuss individual cases in Panel was approximately four minutes. This should be considered in the context of the variability of recordings, including missed and non-recorded events. However, it illustrates the average amount of time professionals take to consider referral information for such children.

Professionals spoke on average for approximately eight minutes in pre-assessment discussions and for approximately 26 minutes in post-assessment discussions.

Time was also reflected in the progression of each child's age, from referral to the point of case closure (see Table 5, p. 56). The average length of time spent by an individual case 'in' the professionals' pathway was eight months.

3.6.3. Data Transcription

Knowledge to be gained from qualitative research activity is dependent on the use of language data and how audio records are converted into written text – specifically what to represent, not

represent, and how to represent it (Cohen et al., 2007). Transparency of choice assists with credibility, presenting a more solid basis for later research claims (Skukauskaite, 2012).

There are two main approaches: *naturalism*, in which every expression is transcribed in fine detail; and *denaturalism*, in which any distinctive sounds (stutters, pauses, non-verbal and involuntary vocalisations) are removed (Oliver, Serovich, & Mason, 2005). Although a denaturalised system is commonly used in CGT to uncover meanings and perceptions (Charmaz, 2000), the Jefferson system (2004) can 'lay out' text in a naturalised format, to gain a richer sense of the quality and purpose of speaker exchanges (Wiggins & Potter, 2008). Hence, when professionals used a softer or louder tone of voice, interrupt or speak over each other, or appear affected by extraneous noise influences, these are represented in textual form to inform the analytic process (Bailey, 2008).

Transcription is time consuming and complex. Researchers thus often arrange for others to carry this out. However, this may mean they 'miss out on the kinds of understandings that develop as tapes are transcribed as well as lose control over some of the transcription decisions made' (Tilley, 2003, p. 770). When transferring what is heard into the written form, language is susceptible to the 'double hermeneutic' effect of the transcribers' additional, interpretative viewpoint (Cohen et al., 2007, p. 500). In the current study, the researcher, using a Windows computer and headset transcribed all recorded events verbatim. Transcription was conducted simultaneously with data collection and coding. Panel meeting recordings were transcribed first, followed by data from the assessment phases. Appendix 7.4.3, (p. 222) shows this iterative process. Transcripts are presented using an adapted method of Jefferson coding, marking the time in seconds to denote different speakers chronologically in rows (Bailey, 2008; Jefferson, 2004; Oliver et al. 2005). Annotations are available in Appendix 7.5.1, (p. 253). Transcriptions were transported as Rich Text Files into MaxQDA for coding

3.7. RESEARCHER REFLEXIVITY

At the core of qualitative inquiry is the researcher's influence on the narrative. Reflexivity refers to a researcher consciously reflecting on the research process (Shaw, 2010). Rather than an objective or value-free account, this means adopting a stance toward participant contributions to question 'are they telling me what I want to hear?' and, in the case of developing theory, 'am I seeing what I want to see?' (Wainwright, 1997, p. 7)

Buckner (2005) relates reflexivity as a form of 'social positioning' (p. 61). Considering the reflexive component in this research meant being aware of the social location and researcher (an EP) and the researched (professionals from mixed disciplines, including an EP) influencing the investigation process and outcomes (Buckner, 2005). It was important to keep an open stance about opportunities to explain what was happening in the field, whilst remaining aware the researcher's response to the participants would shape interpretation of the discussions (Buckner, 2005): 'researchers who take an insider's perspective have different starting points, hold different assumptions and likely move in different directions' (Charmaz, 2012, p. 139). Understanding was based partly on prior perspectives of the researcher – not truth per se but a view among many and countering assumptions imposed on interpretations meant looking with care to provide an understanding of the particular situation, before judging attitudes and actions (Charmaz, 2006).

CGT allowed the researcher to ask questions of the data without becoming immersed in the professional's worldview to accept it without question (Charmaz, 2006). Maintaining the constant comparative method of data with data for similarities and for differences, provided an 'analytic sense of the material', permitting 'challenge' to 'taken-for-granted understandings' (Charmaz, 2006, p.54). This presented further as an effective means to counter the EP-researcher

position and any potential bias towards the views and findings.

Validity is enhanced when the extent to which findings may reflect the personal qualities of researchers is made explicit (Silverman, 2011). It was important to be fully transparent in presenting the ‘trail’ towards theory, revealed in part through reflexive notes and memos maintained during the study (see Appendix 7.4.4, pp. 223-231 and 7.4.7, pp. 238-252).

As further counter to possible bias, delaying the literature review helped encourage ‘articulation of ideas’ and avoided importing preconceived notions or imposing them in the coding and analysis (Charmaz, 2006, p. 165). Once immersed in the data, the researcher was no longer a passive recipient of impressions but actively engaged in the cognitive shift of building concepts and categories, based partly on the history of participant-researcher interaction (Charmaz, 2006).

3.8. DATA ANALYSIS

To ensure reliability of methods and practices, researchers must be detailed, open and precise in the provision of an ‘audit trail’ of the procedures they followed (Robson, 2011, p. 174). This section presents the method of data analysis. It outlines the intensive engagement as iterative cycling between data collected from the field, reading and re-reading transcripts and replaying audio records many times. Reflexive processing of all material was conducted simultaneously. Interpretation of the data arose directly from these processes (Yardley, 2000).

Explanation of the CGT coding clarifies how categories and concepts were ‘grounded’ in data (Charmaz, 2006). Processes comprised ‘quick’ codes, followed by open and then focused coding. Emphasis on the use of gerunds in code descriptors helped accentuate actions and processes (Charmaz, 2006). Development of *in vivo* codes and attention to emergent phrases and

discussion flows from textual transcription features, supported coding of professional language patterns (Charmaz, 2006). Conceptual linkages from coded categories, including integration with relevant additional material (reflexive notes, memos and case file content), generated theoretical codes with merger effective in producing the particular theoretical position to the study (Charmaz, 2006; Yardley, 2000).

The detail of the form and use of these procedures, including analysis completion is discussed in the following sections.

3.8.1. Computer Assisted Qualitative Data Analysis Software (CAQDAS)

Text analysis and coding was conducted in MaxQDA (MaxQDA, 2011). CGT lends itself to analysis through computer software with reputedly greater accuracy from tools that collate terms and themes, improving rigour (Welsh, 2002). MaxQDA as a specific CAQDAS supports the systematic approach to conducting CGT. The intuitive design facilitates constant comparisons of data: ‘Coding is relatively straightforward with codes being created, memos attached, and segments of text tagged as analysis proceeds’ (Matthews, 2007, p. 29). Application of code names, their subsequent renaming, moving or other change, are immediately embedded features of the growing data file and represent the evolved nature of the complete coding process. A CAQDAS screenshot shows the overall document and code system organisation (see Figure 5).

The researcher was cautious of the enhancement to accuracy and convenience and mindful not to be over-influenced by the software attributes. It was important to follow its intuitive nature without being restricted by capabilities: for example, creating codes of little value and/or stifling emergence of fluid, creative understandings (Welsh, 2002). The ‘top down’ order of coding was particularly relevant, not least in production of a natural hierarchy of the focused codes, from the sub divisions of smaller open-code ‘bins’ (Matthews, 2007).

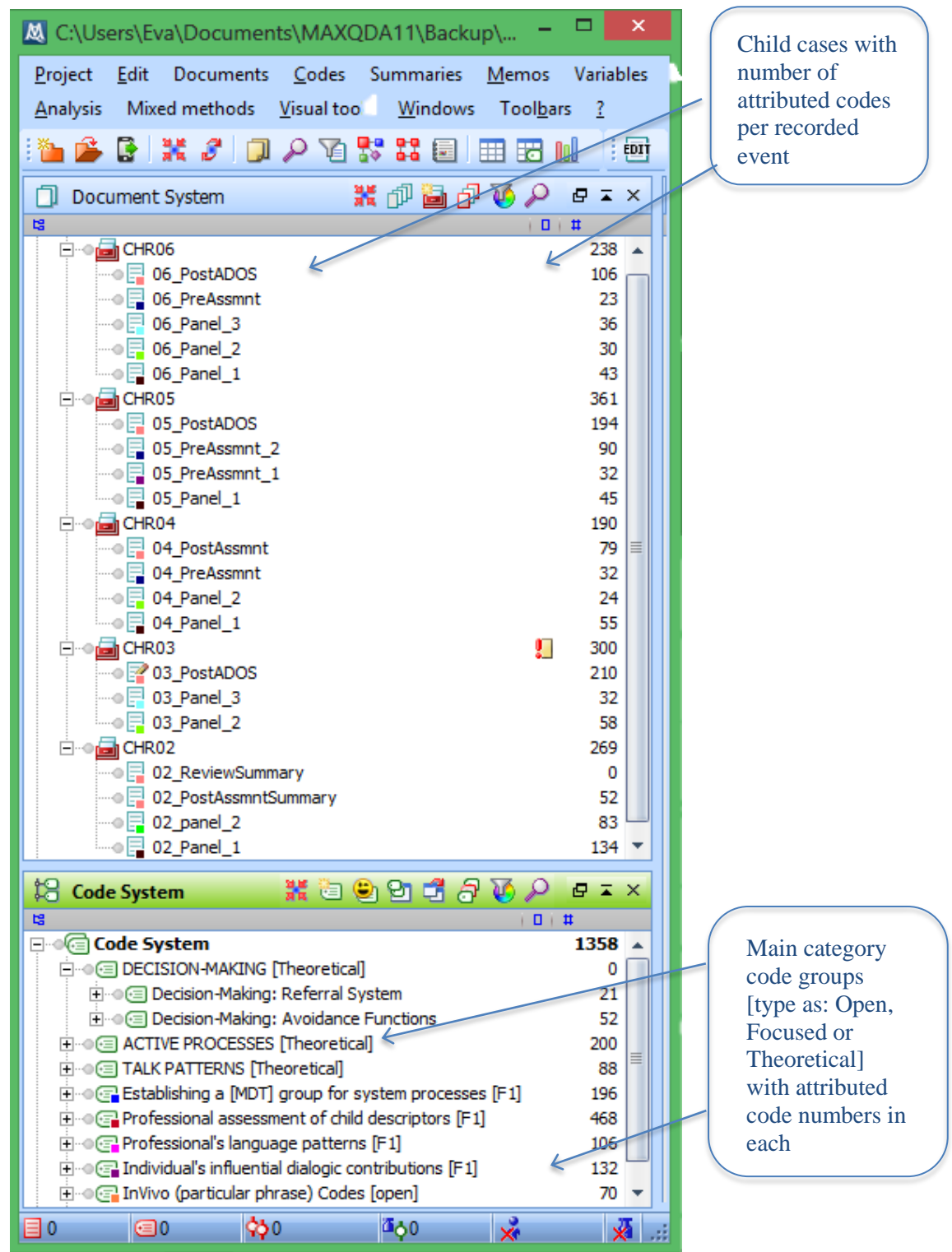


FIGURE 5
MAXQDA SCREENSHOT SHOWING TOTAL CODES PER CHILD CASE TRANSCRIPTION
EVENTS, WITH TOTAL NUMBERS GROUPED AS PRINCIPLE FOCUSED CODE AND
THEORETICAL CODE CATEGORIES⁹

3.8.1.1. Initial 'quick' Codes

As recorded data was received and transcribed, it was treated to 'quick', initial coding, at a descriptive, cursory level, through the 'speed and spontaneity' advocated by Charmaz (2006, p. 48). First ideas and themes emerged in five categories: Systems, Professional Assessment, Professional Interpretation and Professional Action, Professional Dialogue and Influential Dialogic Contributions. These assisted the study focus and underpinned subsequent data categorisations.

Table 7 presents example of initial codes (see Appendix 7.4.1, pp. 210-216, for the first, open codes in their entirety):

TRANSCRIPTION TEXT	'QUICK' CODING, LABEL AND SOURCE
<i>I have(.)a huge number of record of visits from SISS specialist teaching team of their observations of (CHR02) within nursery</i>	CHR02\AssmntSummary Code: Obtaining Information\Observation - setting
<i>Phone calls also with the(.) family health visitor</i>	Code: Obtaining Information\Phone calls
<i>so we need to look at the (3) actual ADOS then don't we</i>	CHR03\Assmnt_1 Code: Obtaining Information\StandardisedMaterials\ADOS
<i>but she is using (...) atleast two or three words(...) together.</i>	Code: Using information\Factual
<i>ok~ (1) erm (3) shared enjoyment. She did look like she was enjoying it(.) but (3) it didn't- (2) [It didn't particularly feel shared]</i>	Code: Using information\Qualitative(feeling)
<i>e'll jus-(.) proceed to a visit?</i>	CHR02\Panel_1 Code: Professional Contributions\Child Plan

TABLE 7

EXEMPLARS TAKEN FROM THE PHASE TO DEVELOP THE FIRST, INITIAL 'QUICK' CODES FROM DATA

3.8.1.2. Open Codes

This phase built on first ideas, with codes re-read and re-named many times, alongside further transcription and coding. Open codes were named segments of text with a concise phrase to account for that piece (Charmaz, 2006). For example, when a particular utterance was made, the

researcher considered the speaker's perspective, using the 'what' not 'why' questioning formula, remaining open, preserving action and keeping close comparison of data with data (Charmaz, 2006).

The promoted use of gerunds¹⁰ gained 'a strong sense of action and sequence' to 'detect processes and stick to the data' and help 'nudge' away from 'static topics and into enacted processes', keeping the objective focus on professionals motives and actions (Charmaz, 2006, p. 49). Attributed data codes, such as 'feeling time pressure', 'working around restricted information' and 'cross-referencing to medical criteria' captured the essence of what was stated. This prevented forcing the data according to researcher pre-conceptualisations; codes were that which professionals spoke (Charmaz, 2006; Yardley, 2000). It helped avoid 'analysis being pinned to certain individuals' (Charmaz, 2006, p. 51), and supports the credibility of subsequent findings.

Specific recorded sounds were significant. *In vivo* codes developed in importance. Charmaz (2006) explains these general terms are ones everyone 'knows' flag condensed, significant meaning, being 'participant's innovative terms' relevant to the context, or 'insider shorthand terms' reflective of a particular group (p. 55). They present with further means to 'anchor your analysis' (Charmaz, 2006, p. 57). Examples of gerunds and *in vivo* codes are presented below and with open code exemplars in Table 8. (*In-vivo* terms and *Significant sounds* codes are shown in the MaxQDA screen images; see Appendix 7.5.3, pp. 255-256).

Gerunds: 'using persuasive dialogue', 'taking a reality check', 'remembering last minute', 'looking for symptoms', 'weighing up conflicting versions', 'applying processes of ADOS'.

In vivo codes: 'hitting a few things', 'job done', '...repetitive...', 'cut off', 'oh gosh', 'reciprocal/reciprocity', and, found as a more impersonal technique: 'we're going to do...', 'who's having that one?', 'right, what's this next one?'

DATA SOURCE: RELEVANT CHILD CASE, EVENT AND LINE NO. LOCATION	DATA AS TEXT SEGMENT	ASSIGNED OPEN CODE
CHR04\04_Panel_1: 9	(...) a:nd (2) asking for (.).if fits ASD	Reason for referral
CHR04\04_Panel_2: 3	02:01:37 (SLT) Trying hard not to lose anybody so let's take this one next (1)	Working to keep track of them all
CHR02\02_Panel_2: 54	I should actually jus≈ (3) no. (<i>taps papers on table</i> x2) I haven't got time (...)	No time
CHR04\04_Panel_1: 58-63	ok. .hh(...) erm (1)so it's going to be that option but we need to (<i>keyboard clicking</i>)(1)complete.(...) 01:06:05 (M) I didn't I looked on our da- on our database an [didn't] pick him up either 01:06:07 (SLT) [Ok̄] 01:06:09 (M) so that's weird (.)(2) 01:06:09 (SLT) Ok̄≈] (1) which might mean he's quite new?(1) 01:06:13 (M) Mm [yeah	Merging and mixing talk
CHR05\05_PostADOS: 592	(TCHR_7) so now we just write here meets autism cut off	InVivo (particular phrase) codes: 'cut-off'
CHR05\05_PostADOS: 213	(SpHV) an you jus repe- it was repetitive wasn he	InVivo (particular phrase) codes: '...repetitive...'
CHR03\03_PostADOS: 167	has to be a ((<i>sniff</i>)) (3)	Significant sounds
CHR02\02_Panel_1: 29	(EP) No I'm just looking (<i>sound of heavy pen scraping</i>) (1)	Significant sounds

TABLE 8

EXEMPLARS OF TEXT SEGMENTS WITH THE DATA SOURCE AND RELEVANT ATTACHED OPEN CODE

3.8.1.3. Focused Codes and Constant Comparison

From open codes, the analysis was raised to the level of focused description (Charmaz, 2006). This phase, instrumental in sifting through large amounts of data to use codes with most analytic sense (Charmaz, 2006), was dynamic and involved continuous 'fine-tuning'. Whilst new code-naming continued where relevant, codes were sorted and synthesised, integrated and organised into categories. Some code names were changed for better descriptors of the concepts, or for data

linked together in new ways leading to emergence of new categories or the integration of existing ones (Charmaz, 2006). This refinement was effective to move the data set ‘upwards’.

The constant comparative method maintained momentum ‘by moving back and forth between the identification of similarities among and differences between emerging categories’ (Willig, 2013, p. 71). Such attention to detail and the natural quality of category naming revealed the complexity and diversity of the data, demonstrating any possible over-regimentation in description managed by the researcher (Willig, 2013). Background as an EP assisted with theoretically sensitive naming of properties, using the analogy ‘open mind’ not ‘empty head’ (Dey, 1993, p. 65).

Table 9 shows example of the arrangement of data within MAXQDA:

Code Group:	<u>Professional assessment of child descriptors</u>
Focused codes	⇒ Professional assessment of child descriptors (F1) ⇒ Significance of parent (mother) contribution (F2) ⇒ Recounting knowing Mother (F3)
Open code	⇒ Through intervention delivery (O)
Text segment	19:39 (TCHR_1) His(.) mum did my] understanding child’s behaviour course- (CHR02\02_Panel_1: 9-10)
Open code (continues from above)	⇒ Using knowledge of parent same as knowing child (O)
Text segment	19:34 (TCHR_1) I know him. (1) (CHR02\02_Panel_1: 6-7)

TABLE 9

MAXQDA DATA ARRANGEMENT: SAMPLE OF TWO TEXT SEGMENTS WITH THE NAMED OPEN AND FOCUSED CODE CATEGORIES

The two transcript samples (blue text) are directly under their named open code (O) (black text), with the steps (in this case, three) of the focused codes forming above as the overall category group (red, underlined text). In this example, the two texts uncovered from the dialogues, labelled to represent the professionals’ experience of ‘*Recounting knowing Mother*’ (focused, F3

code), fulfilled a part of the categories above: ‘*Significance of the parent (mother) contribution*’ (focused, F2 code) and ‘*Professional assessment of child descriptors*’ (focused, F1 code).

By sorting and continuous organisation of separate units of meaning in the open and focused codes, distinctive properties of professional discussions emerged. Active professional processes occurred from the refinement of two code groups: system processes and assessment of child descriptors. Intersecting these, independently and/or overlapping, interactive codes were constructed as a description of professionals’ language patterns and individual, influential dialogic contributions (see F1 categories, Figure 5, p. 69). MaxQDA screen images of the focused (F1, F2, F3) codes, and more compact group examples of open-codes are presented in Appendix 7.5.3, pp. 255-256, 257).

Further refinements of code groups, with reference to other data points as theoretical integration, established theoretical codes (Charmaz, 2006).

3.8.1.4. Theoretical Codes

Charmaz (2006) describes this final phase as a ‘sophisticated level’ of selective coding from the focused codes, by examining possible relationships between substantive categories (p. 63). This linked the uncovered professional’s system and assessment code categories, raising theoretical codes describing the *Active processes* of professionals in the *Referral System*, in which was the child *Assessment ‘pathway’*. *Professional Talk Patterns* emerged theoretically from particular coding of *Talk Exchanges* and pertinent *Individual Contributions*.

This level of theoretical description supported emergence of a conceptual description of the processes used by professionals in joint decision-making. These CGT, conceptual categories were *Decision-making: Referral System* and *Decision-making: Avoidance functions*.

Theoretical codes using CAQDAS screenshots are presented in Appendix 7.5.3, (pp. 258-259).

Comparisons with salient content in researcher memos and reflexive notes supported this refinement of the emerging code patterns (Charmaz, 2006). Explanation of these particular techniques and the decision to discontinue code description where theoretical sufficiency was apparent (Dey, 1999), are described in the following sections.

The complete set of open, focused and theoretical coded data with the transcripts, developed within MaxQDA, is available on CD Rom in Appendix 7.5.2, (p. 254).

3.8.2. Memo Writing and Reflexive Note-making

Memo writing is implicated as a pivotal, intermediate step from data collection to theory formation, prompting data analysis and coding early in the research process (Charmaz, 2006).

In this instance, the researcher's memos were short, succinct statements, formed of ideas and thoughts simultaneously called to mind during the transcription and coding phases of analysis and reflected questioning of professional actions and utterances in the recordings. Capture was either next to text segments to which they related, or next to particular codes, if relevant.

Tables 10 and 11 (pp. 76-77) illustrate the nature of memo writing. Memos allow meaningful links amongst coded categories and sample of their integration by the researcher, as they supported theoretical code formations is shown in Appendix 7.4.5, (pp. 232-234). All memos are available in Appendix 7.4.7, (pp. 238-252).

Researcher reflexive notes, as a 'running stream' of thoughts and ideas that occurred for the duration of the study from first entry to the Centre to the end of data collection and analysis, were linked to the crystallisation of ideas in the theoretical phase (Charmaz, 2006; see Appendix 7.4.4, pp. 223-231).

RELEVANT CHILD CASE AND EVENT	TEXT SEGMENT	GENERATED MEMO [NO.]
CHR04\04_Panel_1 Line 32	01:05:04 (EP) Ok. So we just-(.) if you send- 01:05:06 (M) You see- 01:05:06 (EP) The stuff an then- 01:05:08 (SLT) I would c c̃c̃ (<i>shuffling of papers</i>) 01:05:11 (EP) If it's more than a couple of months we'll go and see him (1) nearer the assessment time(1) 01:05:16 (M) His older sibling (name)has a diagnosis of ASD̃ (1 st name 2 nd name)?(1) 01:05:20 (EP) Ahh that rings a bell [to me- 01:05:22 (M) Yeah] 01:05:22 (EP) -for some reason	[201] Each individual's sentence is broken up, punctuated by the next persons ** BA group ** ?
CHR02\02_panel_2 Line 31	18:57 (SLT) (EP) you've made a≈(.)a comment that there is consent for the research on this child (1) and we need to record the panel discussion (1) so (R) I hope you're listening to (CHR02)(...) 19:09 (EP) ok. jolly good. 19:10 (SLT) (CHR02) is the er::m (2) again I'm no≈t sure of the visit date (1) erm but she signed it off on the 12 th of the 6 th ?	[159]. Reading aloud from referral form. Is the 'reader' in stronger, (control) position (it's usually SLT doing it; has been offered to M occasionally...?) Think about: SLT/M relations; SLT/EP relations; SLT/TCHRs relations Also, when SLT says 'right', 'ok', 'erm' ... a voice of 'pronouncement'?
CHR05\05_panel_1 Line 10	43:51 (M) [yeah] Yeah I am 43:53 (SLT) Good. Well [done]. 43:55 (M) She's my [friend ha ha] 43:55 (EP) [Ha ha] 43:56 (SLT) [ha ha] Right	[211] The threesome of SLT/EP/M seems key. (A triadic relationship). EP & SLT = friction M = often the appeaser; M & SLT = humoured relationship. EP = often the pragmatic, sobering influence.
CHR02\02_Panel_1 Line 62	22:48 (SLT) <u>Write] that down for us then</u> 22:49 (TCHR_1) [Ok 22:50 (SLT) Erm](...) <u>put it on there as well</u> so (.) [erm 22:53 (EP) Was anybody] else involved? (.) at the moment (1) (name) speech therapist 22:59 (SLT) Health visitor (name) (<i>computer keys tapping</i>) (3)	[5] EP keeping focus on the task EP specific task, though to keep database updated, so seeking the information needed to do the job...

TABLE 10

MEMO EXEMPLARS WITH RELATED DATA SOURCE AND TEXT SEGMENTS

CODE	MEMO CONTENT
Professional Assessment of child descriptors	From use of codes, apparent that to assess is the primary role/ focus, of the Centre. Professionals sifting through +ve and -ve attributes of child and weighing them up... Actions seem to be about gathering together other people's information? So the initial visit appears as a comprehensive parent interview; SISS provide the observation information (from setting). ADOS is an assessment tool which involves collating a descriptive feedback of the child (abstract looking) at what they did/ did not do, whilst on a visit to the Centre.
Significant sounds/ 'sniffs & sighs'	Links to code memo (repetitive); all the profs 'pained' sniffing/sighing, a possible reflection of the monotony of their work - is that the mirroring of the nature of the child's difficulties... isolating type work ... links to a previous feeling of trying to draw in others to be more involved, but not successful, and being overlooked by SWrs generally and specifically (eg-CHR05).

TABLE 11
EXEMPLARS OF CODE MEMO CONTENT

3.8.3. Theoretical Sufficiency

Saturation depends upon the scope of the study and theoretical sensitivity of the researcher, by definition ensuring replication in categories providing comprehension and completeness, with decreasing interrogation and increasing abstraction of data (Morse, Barrett, Mayan, Olson, & Spiers, 2002). At such a point, data no longer yields new properties or further theoretical insight (Bryant & Charmaz, 2007; Charmaz, 2006). Dey (1999) favours final analysis established from 'categories suggested by data', preferring the term 'theoretical sufficiency' to saturation (p. 257). Categories may be sufficiently developed, allowing exploration of their relationships, and conclusions (Dey, 1999). The following qualifies how theoretical sufficiency of emergent codes for the particular child cases accounted for completeness in this study.

3.8.3.1. Decreasing Interrogation; Increasing Abstraction

The researcher transcribed all recordings and made frequent (up to five) passes of the data, reading and re-reading transcripts alongside audio playback. Immersion kept the professional

dialogue ‘real’, represented also in the transcription notation style and promoting sensitive interpretation of received discussions.

The application of *in vivo* coding, gerunds and close, precise naming of codes, with the use then of interpretive and illustrative frameworks, demonstrate a full and complete interrogation of data (Charmaz, 2006; Morse et al., 2002). From rich detail in open, descriptive phases, analysis gradually and naturally decreased through focused coding, with full abstraction evident in theoretical codes. The level of frequency to codes for CHR02 reflected its position early in the analysis. CHR03 and CHR05 generated more codes where recordings covered both pre- and post-Centre specific assessment (not captured in other cases) and CHR05 included an additional pre-assessment event due to non-attendance of the first arrangement. Although full saturation in the instance of CHR06 did not occur, the fewer codes found for CHR04 and CHR06, analysed later, were due to data sufficiency (Dey, 2007). Coding of full transcriptions provides ideas and understandings that otherwise might be missed (Charmaz, 2006). Later discussions did not produce new coded material, but extending recycling and recoding confirmed alternative explanation or description was not overlooked.

3.8.3.2. Theoretical Sampling

The conceptual categories suggested by analyses were checked (Charmaz, 2006). Where the method may vary, its purpose in ‘gathering pinpointed data’ from observation, interview or studying documentation, is reliant upon ‘interactional reciprocities and situational demands’ (Charmaz, 2006, p. 110). In this instance, reference to the content of the child’s Centre case file helped confirm the claims developing from analyses. Five files were inspected: CHR01, CHR02, CHR03, CHR04 and CHR05. This further confirmed that categories were at least sufficiently described in this study context (Charmaz, 2006; Dey, 1999).

3.8.3.3. Time in the Field

Collection of the different recorded data sources alongside transcription and coding progressed over a 15 to 20 month period. Time in the field, in conjunction with the comprehensive analysis suggests ‘theoretical sufficiency’ (Dey, 1999, p. 117). The cycle of data collection over time is presented in Appendix 7.4.3, page 222).

3.8.4. Reliability and Validity

Where audio records were directly from the situation in which professionals lead their working lives, confidence in the findings as a valid measure of the phenomena in question was possible (Yardley, 2000). Recordings of professionals’ discussion of these individual child cases provided an opportunity to construct meaning surrounding their decision-making, providing insight into possible causal relationships, i.e. data as constructions of professionals’ decision-making, potentially leading to child outcome. This enabled a higher level of confidence in the ‘truth’ or credibility of the findings (Pidgeon & Henwood, 1997).

The transcriptions using the Jefferson coding method allowed full expression of detail, was reliable, and provided a valid means of analysing the social linguistic functions (Silverman, 2011; Yardley, 2000).

Researcher codes were initially developed from the smallest possible relevant ‘chunks’ of meaning: text was reduced to a single word, sentence or short phrase, through careful line-by-line analysis. This micro-scrutiny enabled a representative and valid interpretation of actual work engagement (Charmaz, 2006). The researcher gave careful thought to what professionals said, as much as possible from their point of view, avoiding undue influence either from researcher-

preconceived ideas, or from any possibility of passive acceptance to the professionals' point of view (Charmaz, 2006).

Combined with fine detail to coding, verification mechanisms were employed to contribute further to the reliability and validity and thus, the rigor of the study (Morse, et al., 2002). This included the researcher's systematic data checking and confirmation, with continual focus on the research question. The process of iteration ('cycling' between interpretation and collection of data) and repeatedly reformulating and examining revised interpretations in light of further examination of evidence (Stiles, 1999), helped ensure the fit of data and a continual monitoring of analysis and interpretation (Morse et al., 2002).

The extent to which a study is reliable and valid also rests upon how it is found to be 'sound, legitimate and authoritative by people with an interest in research' (Yardley, 2000, p. 235). Professional colleagues, the researcher's academic tutor and other tutors and scholars known to the researcher through the Tavistock professional doctorate, concurred about the fit of the methodology and coding interpretations. Anonymous samples of transcribed data are presented with the researcher's initial coded perspective available in separate form. Researcher interpretation and data coding were therefore subjected to 'checking' (Charmaz, 2006). This consensus about appropriate data analysis and the fit of code description was useful when developing the concepts informing analysis (Charmaz, 2006). Examples of verification sampling are provided in Appendix 7.4.2, (pp. 217-221).

3.9. CHAPTER SUMMARY

In conclusion, this chapter presented the storyline as to the conduct of the study. An outline of relevant social constructivist and relativist positions informed the qualitative methodology,

explained the use of CGT and provided a rationale for a psychoanalytically informed approach to analysis.

The recruitment and involvement of child subjects and professional participants was described. Ethical implications were considered. Qualitative data was collected in the form of discussion recordings. Data were analysed using CGT. The steps to this data treatment clarified how theoretical code findings emerged from the constant comparison of open, focused codes and the merger of additional sources of information in reflexive researcher notes, memos, and checking child case file contents. Description included an account for the trustworthiness of these methods.

In the next chapter, CGT findings are presented.

CHAPTER 4: FINDINGS

In this chapter, the findings of CGT analysis are presented. Code ‘maps’ demonstrate links between coded categories and theories, and describe the MDT working model used for these child cases.

Key findings from discussion transcripts for *active processes* and *talk patterns* determined the theoretical position of the study for the processes found used in the professionals’ decision-making. These occurred in relation to professional operation of the *Referral system* and *Avoidance functions*. Prominent coded text excerpts illustrate particular concepts and the chapter closes with a summary, setting the context for theoretical discussion.

4.1. THEORETICAL CODE ‘MAPS’

The most salient codes, which raised key conceptual findings for active processes, talk patterns and decision-making aspects of professionals’ work, are in colour code ‘map’ displays (Figures 6-9, pp. 84-87).

Links from open codes to focused codes show how professional decision-making processes, according to the theoretical *Active Processes* and *Talk Patterns*, possibly influence the particular outcomes for these child cases. The theoretical position from this merger, potentially descriptive of the decision-making used in these particular child assessments are coded under *Referral System* (see Figure 6) and *Avoidance Functions* (see Figure 7). The significant uncovered *role functions* operating in the system are further illustrated (see ‘maps’, pp. 86, 87).

From illustrative code maps, description of the key findings follows, with an overview first of the MDT Referral System and Assessment ‘pathway’, then description of the particular theoretical categories and position of processes found in MDT decision-making.

The table below provides a key to levels and colour used in the code ‘maps’:


Colour text	Category	Position/Significance
[Black text]	[O] [F3] Open, or focused (F3), codes	Forming up of F1/F2 focused categories
Green text 	Theoretical codes	Final conceptual analysis position with arrows showing code links
Bold:		
Blue text	Establishing a [MDT] group for system processes	Particular codes linked to theoretical position codes
Red text	Professional assessment of child descriptors	
Pink text	Professionals’ language patterns	
Purple text	Individual’s influential dialogic contributions	
Orange text	<i>In Vivo</i> codes	
Brown text	Significant sounds	
Pale:		
Blue Red Pink Purple Orange Brown	[F1, F2, F3] [F1, F2, F3] etc	Surrounding open, or focused, level codes, supporting shown, linked codes

TABLE 12
KEY TO USE OF COLOUR CODED GROUP CATEGORIES USED IN THEORETICAL POSITION CODE ‘MAPS’
(FIGURES 6-9, PAGES 84-87)

Decision-Making: Referral System

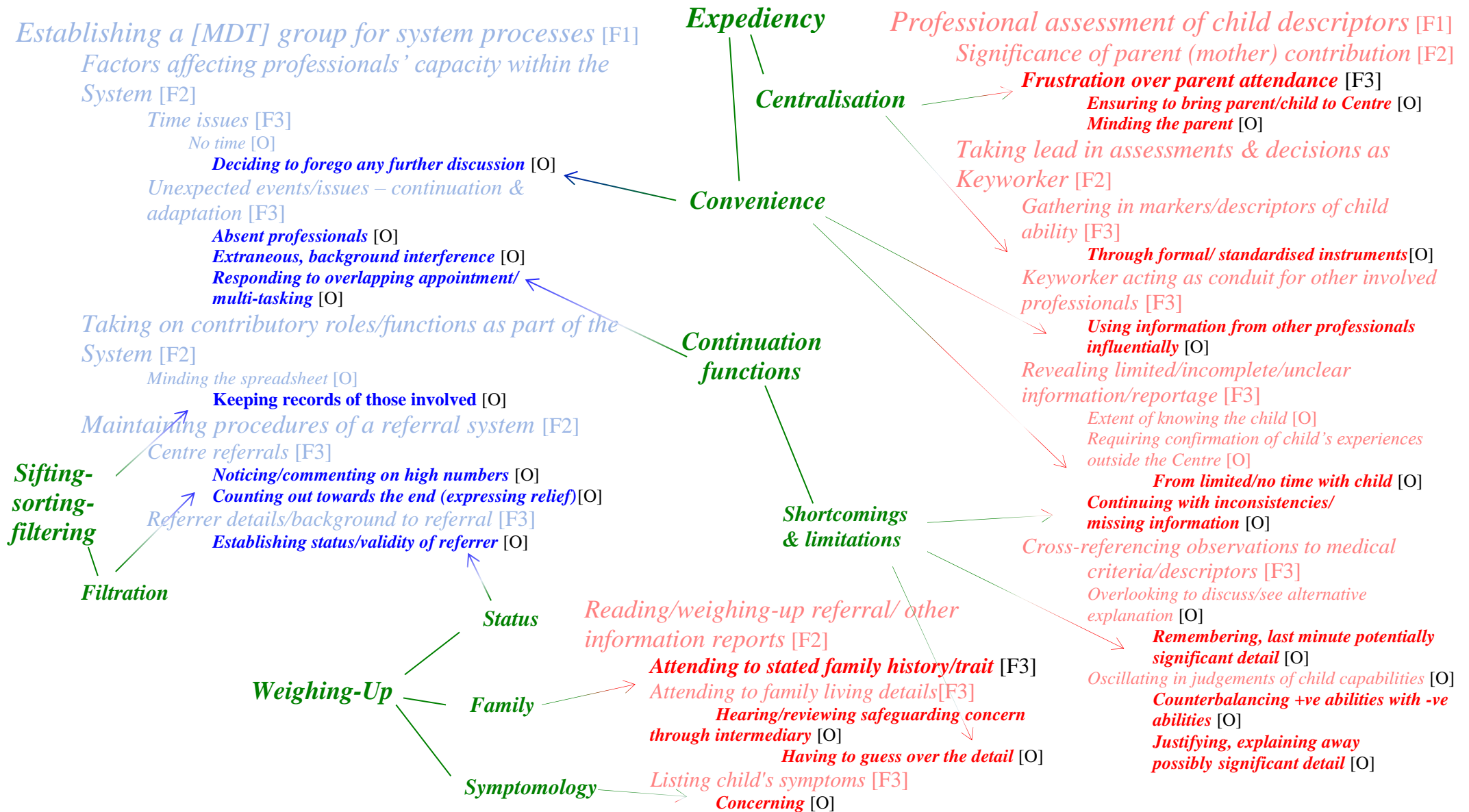


FIGURE 6
CODE MAP SHOWING LINKAGES FOR THE THEORETICAL, DECISION-MAKING CODES: REFERRAL SYSTEM

Decision-Making: Avoidance functions

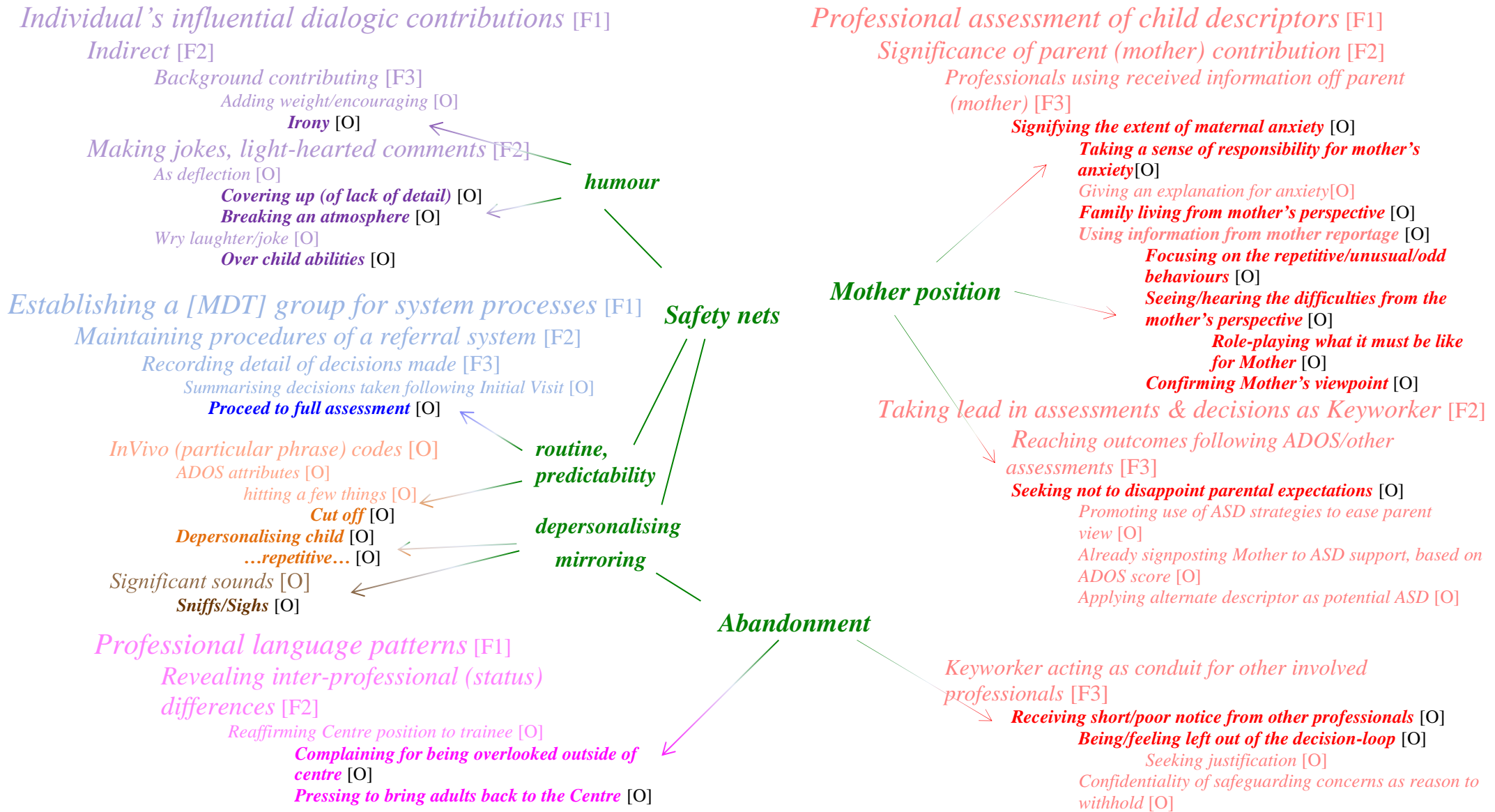


FIGURE 7

CODE MAP SHOWING LINKAGES FOR THE THEORETICAL, DECISION-MAKING CODES: AVOIDANCE FUNCTIONS

Decision-Making: Adopted Roles in System Maintenance
[controller; guardian; pacifier]

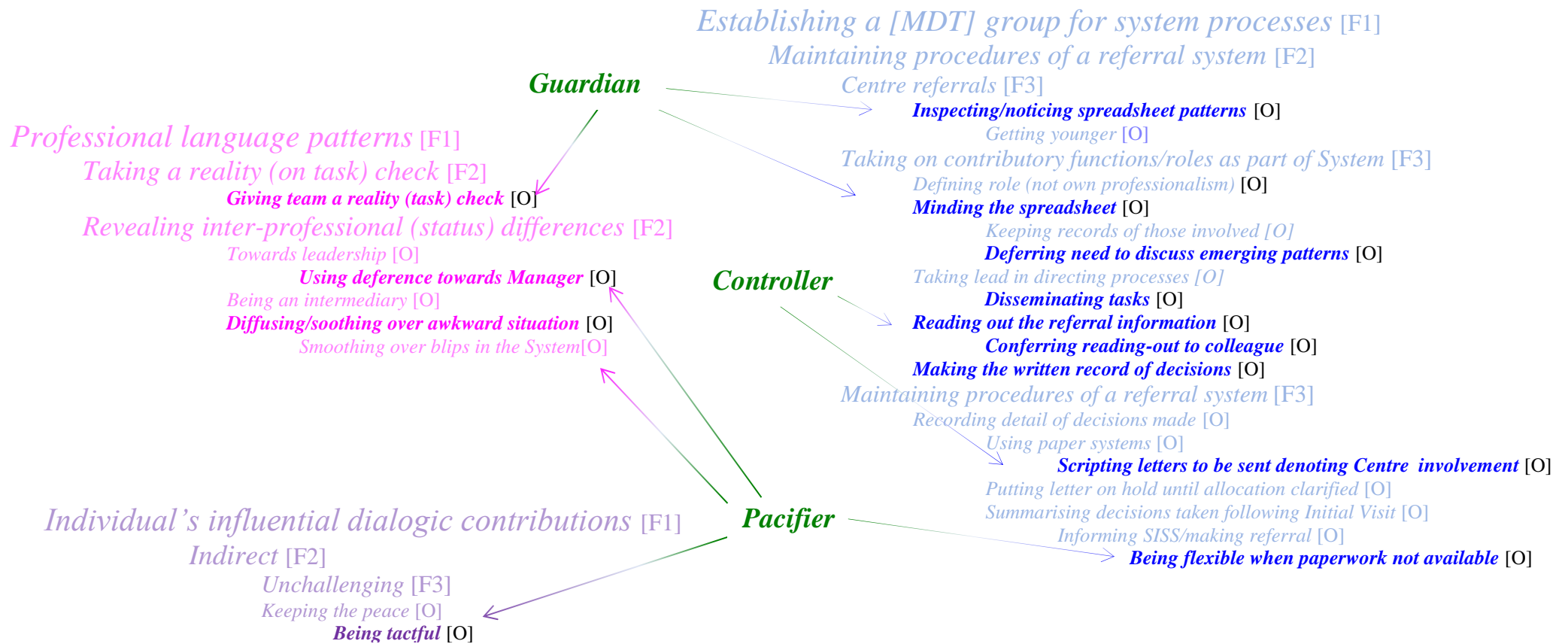


FIGURE 8

CODE MAP SHOWING LINKAGES FOR THE THEORETICAL, DECISION-MAKING CODES: ADOPTED ROLES IN SYSTEM MAINTENANCE (CONTROLLER, GUARDIAN PACIFIER)

Decision-Making: Adopted Roles in System Maintenance
[mother figure; bystanders-absentias-absconders]

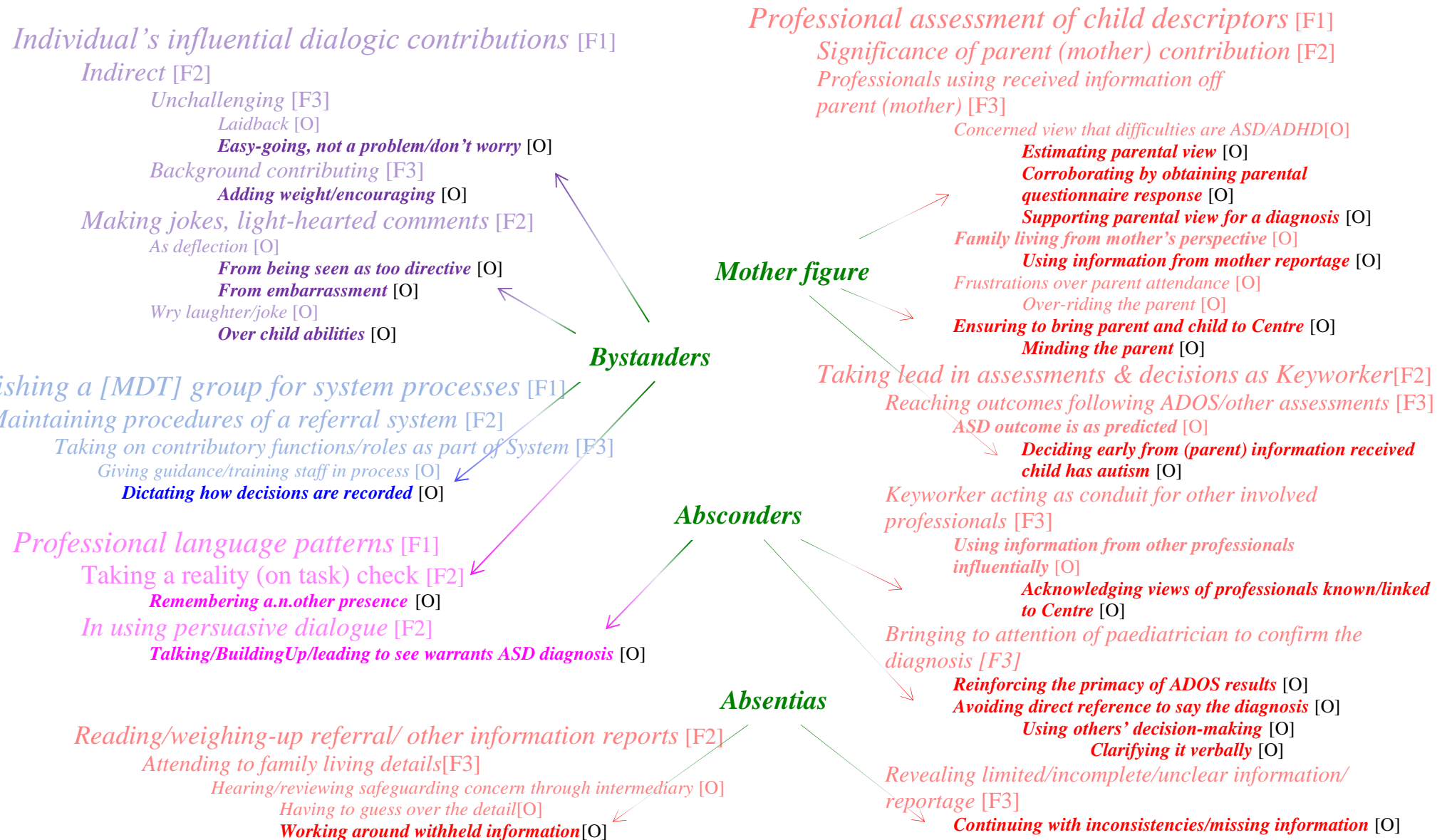


FIGURE 9

4.2. A 'FRAGMENTARY' MDT MODEL

The study explored decision-making processes in a mixed MDT. The child assessments in this context were fragmented.

Some professionals maintained their distance, although in transcripts heard to have a significant role in these child assessments. Others filled in forms to make referrals - those who knew the child but were not present in person (although during Panel 1, TCHR-1 claimed to 'know' CHR02). Health professionals contributed indirectly – speech/language, audiology, occupational and physiotherapy professional input was apparently through singular, alternative arrangement, with analysed discussions indicating feedback then provided to the Keyworker.

During data collection, staff absences and 'multi-disciplinary' panel decisions required solo or dyad discussions (see Table 6, p. 62). In the referral system, the core team (Centre Manager (SLT), the Under-6 Team Lead (EP) (both Centre-based), and the SISS Manager (M) (non-Centre-based) were routinely involved in panel meetings, although not necessarily always together. Hence, core specialisms available at these MDT discussions included a speech and language therapist (also Centre Manager), an EP (also Under-6 Team Lead) and a specialist teacher (also Manager SISS (Early Years) team). At varying times, they were joined by different qualified teachers from the SISS team (also non Centre-based).

For these child cases, the MDT panel of professionals had backgrounds in education and health. The fact that they also held management positions appeared to affect the content of their discussions, with a focus mainly on systems aspects than on a specialist understanding of the needs of the child. An exception to this was the EP, who twice asked questions pertaining to child age and educational provision.

4.2.1. Child Assessment ‘Pathway’

Findings relevant for these child cases revealed a referral system route, following particular information-gathering junctures. This MDT pathway of assessment practice is illustrated in Figure 10.

Data was gathered at initial referral in Panel 1. Next, a developmental history was taken during a single visit to the child and family home and recommendations were made to Panel 2. Children were allocated to a Keyworker after Panel 2, if relevant; in such instances, a waiting period ensued. Further information was gathered by the Centre-based Keyworker and the conduct of the ADOS assessment (also Centre-based) with the child, in the company of the parent (in all these instances, the mother). On the basis of an established numerical score from the ADOS assessment, the Keyworker reached a clinical diagnostic decision and, where relevant, requested that the Paediatrician confirm a diagnosis of ASD via a parent and child consultation.

Analyses revealed that medical discourse prevailed in understanding these cases. The decision-making of mixed MDTs may influence child outcomes. These cases all received a diagnosis: ADHD (CHR01), ASD (CHR02, CHR03, CHR04 and CHR05) and Specific Language Impairment (SLI) (CHR06).

Decisions made by this team followed an inter-dependency cycle. Factors influencing one aspect influenced other parts of the system. Professionals used the following processes to make decisions: *System routines*, *Weighing-up significance*, *Expediency*, including *Centralisation* and *Convenience*, *Continuation of Function* and, emerging more from coded language patterns, *Avoidance of Difficulty* and *Unpleasantness*.

In the following sections, these key findings are discussed. Transcript excerpts are used to illustrate the concepts. Text segments are in tabulated rows, with their origin and code label (focused (FC) or open (OC)). A list of abbreviations used to denote the professional speaker (in parenthesis) is available (see Table 6, p. 62), as well as a copy of the transcription notations (see Appendix 7.5.1, p. 253).

4.3. KEY FINDINGS: ACTIVE PROCESSES

In this section, processes derived from professional discussions are described, making evident the referral system in which the child assessment ‘pathway’ operates.

4.3.1. Referral System Routines

Decisions maintained the referral system used by professionals. External professionals alerted those in the Centre to child concerns, questioning whether ASD was relevant.

i	(SLT) (CHR02) has seen (name) speech therapist (..)who has referred him here (2) (<i>mouse clicks</i>) 19:56 (SLT) did the referral come from (name)? (<i>keyboard clicking</i>) Is that? (...) right? (...)chronology? 20:02 (EP) erm .hhh (2) yes the referral was from speech therapist. 20:06 (SLT) ok	[REVIEWING/CHECKING ACCURACY OF REFERRAL (OC)] (CHR02\02_panel_2: 39-42)
ii	(EP) an this is a young girl who's 5(. no 4 she's 4 01:00 (EYPrac) Four 01:01 (EP) Big for 4 ha ha 01:02 (EYPrac) [5 in march next year] 01:03 (EP) [An and the query] is whether she has(.) erm ASD	[REASON FOR REFERRAL (OC)] (CHR03\03_PostADOS: 103-107)

The Centre provides an encouraging *open-door* arrangement for both professionals and parents.

Professionals commented frequently about the high numbers of children in the system.

i	01:24:24 (M) And the last one for the day(...)(CHR03)	[COUNTING OUT TOWARDS THE END (EXPRESSING RELIEF) (OC)] (CHR03\03_Panel_2: 26)
ii	01:03:20 (SLT) OK. Done (1)	[IN VIVO CODE: JOB DONE (OC)] (CHR04\04_Panel_1: 4-5)
iii	(01:06:29 (SLT) Next one is -	[MOVING ONTO NEXT CHILD (OC)] (CHR04\04_Panel_1: 76)
iv	01:20:45 (M) Two to go(.)Two to go ... 01:21:12 (M) Ha ha we still here (...) 01:23:55 (M) and last but not least	[NOTICING COMMENTING ON HIGH NUMBERS; REFERRING TO THE LENGTH OF TIME IT TAKES; COUNTING OUT TOWARDS THE END (EXPRESSING RELIEF) (OC)] (CHR03\03_Panel_2: 17-22)

The 'conveyor-belt' effect of high numbers made it difficult for professionals to retain a sense of where children were in the system, and led to notice by some for younger children being referred.

i	21:04 (EP) No I'm just looking (<i>sound of heavy pen scraping</i>)(1) there's a huge number these referrals (..) are under <u>three</u> 24:56 (SLT) Yeah (CHR02)'s uncle	[INSPECTING/ NOTICING SPREADSHEET PATTERNS (OC)] GETTING YOUNGER(OC) PUSHING ON WITH THE PROCESS (OC)] (CHR02\02_Panel_1:29)
ii	02:01:37 (SLT) Trying hard not to lose anybody so let's take this one next (1)	[WORKING TO KEEP TRACK OF THEM ALL (OC)] (CHR04\04_Panel_2: 3)

A regular element of system functions was record-keeping routines and recognition of evidence for decisions made.

-
- i 01:42 (SpHV) We have(.) I'm going through the file as I'm spea≈king now(..)
 [KEEPING INFORMATION TOGETHER ON CHILD IN CASE FILE (OC)]
 (CHR02\02_PostAssmntSummary:18)
- ii 01:05:46 (SLT) So be er hard to do the letter(.) hold letter≈ (2) until-
 [PUTTING LETTER ON HOLD UNTIL ALLOCATION CLARIFIED (OC)]
 (CHR04\04_Panel_1: 50)
- iii 01:20 (EP) (*pen writing*) but (1) we need to make a note that there are difficulties with the blocks bit so we've got(.) all the notes haven't we
 01:26 (EYPrac) Yeah we've got the notes from what she said
 01:28 (EP) I think its always better to(1) like we have to err on the side of caution really
 01:33 (EYPrac) Mm hm [ENSURING DECISION EVIDENCE (NOTES) AS USED IN ASSESSMENTS (OC)]
 (CHR03\03_PostADOS: 262-265)
-

A signature indicated actions taken based on referral details. Files contained documentation and spread sheets were the recording mechanisms during panel discussions.

-
- i 01:39 (EP) Who else is he known to?
 01:40 (M) I've made a referral to speech therapy
 01:42 (EP) SaLT (1) 'k≈ SaLT and needs [OT and Paed] (*keyboard clicking*)
 01:46 (M) [OT and Paed] yep (2)
 [KEEPING RECORDS OF THOSE INVOLVED (OC)]
 (CHR06\06_Panel_3: 19-22)
- ii 01:24:47 (M) Mm we've got a referral to SISS. an≈ initial visit on the 25th of April
 [INFORMING SISS/ MAKING REFERRAL (OC)]
 (CHR03\03_Panel_2: 29)
-

As well as tracking children in the system, reference was made to time: professionals had their own term 'clock ticking' indicative of the NHS's established measure of service effectiveness. Once received, referrals were date stamped and there was an 18-week window in which to conduct a home visit. When this was accomplished, the 'clock' could 'stop'.

-
- i 02:03:22 (SLT) This is the problem as to how it goes on and on for a long time now you can see why our 18 weeks becomes a problem
 02:03:27 (TCHR_4) Yeah
 02:03:29 (SLT) because it was open to us now on the 18th of the 6th so we're more than(.) we've used 4 weeks already and we've done nothing(1) so it's not long≈ really is it?
 02:03:38 (TCHR_4) [Yeah]
 02:03:39 (SLT) [weeks just] tick by so we need to know do we get started or do we not. really.
 [FEELING PRESSURE – OFFICIAL TIME CLOCK (TICKING) (OC)]
 (CHR04\04_Panel_2: 11-15)
- ii (SpHV) so:: (2) the information that we received (.) cos he was referred some time ago now
 [NOTICING TIME/PICKING UP ON MISSED APPOINTMENTS/LIMITED PROGRESS (OC)]
 (CHR05\05_PreAssmnt_2: 11)
- iii (SLT) I should actually jus≈ (3) no. (*taps papers on table x2*) I haven't got time (...)
 [NO TIME (OC)]
 (CHR02\02_panel_2: 54)
- iv (SpHV) now an we need to score .hh I do really need to rush
 15:17 (TCHR_7) I know
 [NO TIME (OC)]
 (CHR05\05_PostADOS: 371-372)
-

A possible repercussion was further wait time after the Initial Visit, before allocation of a Keyworker (see also time description in Tables 5 and 6, pp. 56, 62).

-
- i (SLT) right so(1.5)we haven't even really got(...) children near her allocated yet(2)
 02:14:33 (TCHR_4) She's away off basically (1) yeah em I'm [seeing
 02:14:38 (SLT) yea≈h] [SYSTEM DELAYS; AWAITING ALLOCATION OF KEYWORKER (OC)]
 (CHR03\03_Panel_3: 39-41)
-

These referral systems encapsulated information-gathering junctures on the assessment 'pathway'.

4.3.1.1. Panels

In-coming child referrals were 'filtered' through the processes of Panel. From theoretical analysis, *filtration* involved reviewing incoming information by *weighing-up* the detail read aloud from the Centre's referral form. Professionals gave attention to the *status* of referrer/s, any *family* (ASD) *factors*, and the extent of *pathology* in the child descriptors.

The next sections exemplify each of these.

4.3.1.1.1. Referrer Status

During panel discussions there was a preference for referrals from professionals known in the Centre system, such as paediatricians or SISS teachers.

-
- i** 28:27 (SLT) Ok s' here's yours (EP) (*paper's being shuffled*) o:k(.) GP referral again
 [ESTABLISHING STATUS/ VALIDITY OF REFERRER (OC)]
 28:47 (SLT) Ha Ha Ha (...) right ooh this one's a bit thin so we might not be able to accept this this is a GPs letter (.)
 QUESTIONING TO ACCEPT – LIMITED INFORMATION INDICATES OTHERS NOT INVOLVED (OC)]
 (CHR06\06_Panel_1:16; 24)
- ii** 44:00 (SLT) Ok (3.5)_so we've got another: erm (.) oh we've got a referral form but we've also got attached a:(...) letter from(.) (name) .hh (1) So the referral is from (name) (1) who is one of our~ paediatricians (1)
 [ESTABLISHING STATUS/ VALIDITY OF REFERRER (OC)]
 (CHR05\05_Panel_1: 15)
- iii** 01:04:12 (SLT) Do we just go with it [seeing how he's recommended? -
 01:04:13 (M) Yea~h] [VIEWING REFERRER STATUS AS INDICATOR TO ACCEPT FOR ASSESSMENT (OC)]
 (CHR04\04_Panel_1: 10-11)
-

4.3.1.1.2. Family Factors

Professionals focused on children's medical history, particularly ASD in other family members. Concerns of parents were emphasised at this point (all parents were the mothers; fathers were referenced in some cases).

-
- i** 01:05:16 (M) His older sibling (name) has a diagnosis of ASD (1st name 2nd name)?(1)
 01:05:20 (EP) Ahh that rings a bell [to me-
 01:05:22 (M) Yeah]
 01:05:22 (EP) -for some reason
 01:05:23 (M) and 2 cousins have ASD
 01:05:25 (EP) Ok (2) [ATTENDING TO STATED FAMILY HISTORY/TRAIT (FC)]
 (CHR04\04_Panel_1: 35-40)
- ii** 19:29 (SLT) concerns around possible ASD. (1) the maternal family history of ASD and (names)'s(.) feel that (.) (CHR02) (1) is showing traits of this
 [CONCERNED VIEW THAT DIFFICULTIES ARE ASD/ADHD (OC)]
 (CHR02\02_panel_2: 39)
-

4.3.1.1.3. Pathology

The professionals' attention toward the focus child involved considering symptomology and pathology characteristics particular to ("within") the child.

-
- i** (M) he has (.) delayed gross motor skills delayed expressi- (*adjustment mic.sounds*) expressive language(1) eye contact is variable solitary play very self-directed and repetitive(1) he 'as sensory issues around food and diet olfactory sensitivity extreme tactile sensitivity(1).hh rigid behaviours disturbed sleep pattern (1) which all of these are impacting on his(.) daily living skills (2) [SUMMARISING THE SPECIFIC ASD INDICATORS (OC)] (CHR06\06_Panel_3: 10)
 - ii** 21:29 (SLT) He often(.) displays heightened emotional responses to situations which can be difficult to de-escalate .hh and (CHR02) can become in: consolable .hh he has(.) strong attention to detail and enjoys looking closely(.) at mechanisms toys and everyday objects .hh doors locks and plugs he is fearful of loud noises diagnosis done (*pats table*) [LISTING CHILD'S SYMPTOMS; CONCERNING (OC)] (CHR02\02_panel_1: 30;32)

The established status and significance of referral concerns, relayed by Panel 1, instigated an Initial (home) Visit. This outward routine of whether to conduct a visit was for these child cases, commencement of the assessment process and confirmed in Panel 2 as a 'decision to accept'.

-
- i** 45:35 (SLT) Erm (1) (*flicking page*)
45:36 (EP) Go to (FamCo)
45:37 (SLT) Go for (FamCo) yep(2) [ALLOCATING TO MOST LIKELY TEAM MEMBER TO FOLLOW-UP THE VISIT (OC)] (CHR05\05_Panel_1: 30-32)
 - ii** (SLT) (1) and assessment at the (name) centre with an ASD focus. (3) [PROCEED TO FULL ASSESSMENT (OC)] (CHR02\02_panel_2: 45)
 - iii** 21:38 (SLT) so that's the same(.) (*shuffling paper sounds*) proceeding to assessment(.) [PROCEED TO FULL ASSESSMENT (OC)] (CHR02\02_panel_2: 49)
-

Subsequent to the child's condition reviewed through Panel 2, professionals generated three data-access priorities within the assessment 'pathway': Initial Visit, Observation and formal assessment using questionnaires and, primarily, ADOS. All were apparent in these child cases diagnostic assessment routines and explained further below.

4.3.1.2. Initial Visit

The home visit of an Early Years practitioner entailed obtaining a developmental history of the child from the parent (mother) and leaving relevant questionnaires for completion. Signposting for alternate professionals' involvement (according to information received) and (if not already involved), referral to SISS was initiated at this point, with influential recommendations made towards Panel 2, in these child case incidences for ASD-specific assessment at the Centre.

-
- i** 01:25:21 (M) Ermm (1) referral to SISS it says short sensory profile left (1) referral to audiology (1)
 [REFERRING ON TO OTHER SPECIFIC PROFESSIONAL SUPPORT (OC)
 STARTING ASSESSMENT PROCESS BY LEAVING QUESTIONNAIRES WITH PARENT (OC)
 Accept for under 6 specialist assessment including the possibility of autistic spectrum disorder (3)
 PROCEED TO FULL ASSESSMENT (OC)]
 (CHR03\03_Panel_2: 44)
- ii.** (EP) and she's flagged up that it- the- they will (.) need a paediatric view as well.
 [MAKING RECOMMENDATION FOR A PAEDIATRIC VIEW (OC)]
 (CHR02\02_Panel_2: 44)

4.3.1.3. Observation

A SISS teacher visits the child in the context of a play placement (Primary school/ Nursery/ Pre-school setting) or at home if the child is not in a setting, with this information provided to the involved Centre Keyworker. From these child cases, demarcation of SISS teachers and Centre-based professional practice was evident, with the latter's priority specified as ASD-focused assessment.

-
- i** (SLT) (1) so the plan includes referral to SISS (1) and assessment at the (name) centre with an ASD focus. (3)
 [INFORMING SISS/ MAKING REFERRAL; PROCEED TO FULL ASSESSMENT (OC)]
 (CHR02\02_panel_2: 45)
- ii** 00:58 (SpHV) SISS have also (.) produced a written observations of their records (..)at (.) nursery and their involvement at home
 [GATHERING IN MARKERS/ DESCRIPTORS OF CHILD ABILITY(FC)]
 (CHR02\02_PostAssmntSummary: 13)

4.3.1.4. Assessment (ADOS)

The assessment phase that followed panel ‘*filtration*’ was primarily Keyworker-led. This *centralised* role was a *conduit*, linking other professionals and using processes of *sifting, sorting and filtering* information to make a clinical decision about the child.

The Centre was the primary location for the operation of assessment processes. Child and parent (mother) were ‘expected’ to attend for the standardised ADOS assessment and to complete other relevant questionnaires specified by the Keyworker. This appeared to engage the child ‘in isolation’ of other children and adults as a focused Centre assessment.

-
- i** 02:49 (TCHR_1) but I think praps next time I’ll put it in the diary to [prompt] two days before
 02:52 (SpHV) right
 02:53 (TCHR_1) an the day before
 02:53 (SpHV) yeah
 02:54 (TCHR_1) to get her here
- [ENSURING TO BRING PARENT/CHILD TO CENTRE (OC)]
 (CHR06\06_PreAssmnt: 28-33)
- ii** 03:06 (SpHV) No Ok this is(.) the ADOS module 1
 03:09 (TCHR_7) Mm hm
 03:10 (SpHV) D’ye kno- It stands for autism diagnostic observation schedule
 03:14 (TCHR_7) Mm hm
 03:14 (SpHV) It’s an assessment that’s done all over the wo~rld use the same materials and deliver it in the same manner .hh erm but you use different modules depending on the child’s verbal ability
 03:24 (TCHR_7) Mm hm
- [GIVING GUIDANCE/TRAINING STAFF IN PROCESS (OC)]
 (CHR05\05_PreAssmnt_1:85-90)

Features of decision-making during the ADOS assessment involved the Keyworker retaining a *primary role* in making judgments:

-
- i** 18:06 (SpHV) ... shared enjoyment. now he did show some enjoyment didn’t he
 18:13 (SaLTee) mm hm
 18:13 (TCHR_7) mm
 18:14 (SpHV) I’ll give you the three different things
- [KEYWORKER ESTABLISHING PRIMACY IN ASSESSMENT JUDGEMENTS (FC)]
 (CHR05\05_PostADOS: 435-438)
- ii** 11:48 (SpHV) I’m gonna put with adult initiation (*writing sounds*) and (2) led really cos I was leading him with that
- [HAVING THE FINAL SAY (OC)]
 (CHR05\05_PostADOS: 287)

ADOS involved professional consideration of child behaviour and responses during conduct. In their capacity as lead professionals, Keyworkers *counterbalanced* positive child skills or attributes and contrasting statements. This led to inconsistent decisions and the perspective of the child being overlooked.

When professionals used a *benevolent*, developmental view of the child, outweighing these observed traits occurred by emphasising the difficulties, *overlooking* to discuss a child-centred point of view or finding *potential alternative* explanations. The main features of these assessment decisions were *weighing-up* conflicting versions of the child's difficulties, emphasis on *cross-referencing* child descriptors with *medical criteria*, making *interpretative caveats* for a child's positive responses and basing certain decisions on a *qualitative, 'feeling' sense* of how the child progressed in an assessment.

-
- i** 02:08 (EP) amount of social overtures. Ok (2) ((*sniff*)) I don't know because (1) .hh she was as she was tapping (...) at the end [She tapped me]
 02:21 (EYPrac) [Mmm] she did
 02:23 (EP) erm or she asked didn't she (.) but it (1) it was to do that it was to direct attention(.) to something (1) but it didn't feel very social
 02:34 (EYPrac)No≈ (1)
 02:36 (EP) It really didn't [COUNTERBALANCING +VE ABILITIES, WITH -VE ABILITIES (OC)]
 ...
 04:08 (EP) So I don't think we can give her- (...) I think w- cos its not absolutely ok it didn't feel comfortable [did it
 04:15 (EYPrac) No] MAKING QUALITATIVE JUDGEMENTS/HAVING A FEELING SENSE (OC)]
 (CHR03\03_PostADOS: 32-34;58-59)
- ii** 18:16 (SpHV) a zero is shows definite and appropriate pleasure during more than one activity must include pleasure in at least one activity that is not purely physical like tickling (1) that's zero.
 18:28 (SaLTee) mm
 18:29 (SpHV) one is shows some appropriate pleasure during more than one activity (1)
 two is shows little or no pleasure well he did show some pleasure
 18:37 (TCHR_7) he did show some pleasure
 18:38 (SaLTee) yeh
 18:39 (SpHV) so I would say is one more than a-
 [CROSS REFERENCING OBSERVATIONS TO MEDICAL CRITERIA/DESCRIPTORS (FC)]
 (CHR05\05_PostADOS: 440-445)
- iii** 02:28 Point B is we need 6 symptoms from 1 2 and 3 at least 2 from 1 and working through that criteria(.) erm [CROSS REFERENCING OBSERVATIONS TO MEDICAL CRITERIA/DESCRIPTORS (FC)]
 (CHR02\02_PostAssmntSummary: 23)
-

- iv** he just ignores the other [children] its as if they're not in the [room]
05:29 (Paed) [Yes] (1) [yes] you get that [impression-]
05:30 (SpHV) [that kind of passive-]
05:31 (Paed) Yes [MAKING QUALITATIVE JUDGEMENTS/HAVING A FEELING SENSE (OC)]
(CHR04\04_PostAssmnt: 131-134)
- v** 16:20 (SpHV) that's all the communication ones were very easy. now we're doing reciprocal social interactions now thought the scoring eye contact now. now I did say that he gave me some nice eye contact
16:32 (TCHR_7) mmm
16:32 (SpHV) but we don't- we only get a choice here with this [BRINGING INTERPRETATIVE CAVEATS OF CHILD RESPONSE FITS ADOS (OC)]
(CHR05\05_PostADOS: 404-406)
- vi** an he did used to- he gave a very sort of quiet little smi:le-
02:11 (SaLTee) mmm yeah ye:s
02:12 (TCHR_7) you kept saying that's a nice[smile]
02:13 (SaLTee) [ye:s]
02:15 (SpHV) [little] quiet- it wasn't a big-
02:16 (TCHR_7) yeah
02:17 (SpHV) it wasn't a social smile
02:18 (TCHR_7) no [COUNTERBALANCING +VE ABILITIES WITH -VE ABILITIES (OC)]
(CHR05\05_PostADOS: 60-67)
- vii** 14:48 (SpHV) there's no choice making (2)
14:50 (TCHR_7) I wonder if it if it would have been different had he wanted a biscuit
14:52 (SpHV) yes. well hopefully it would have done but it was interesting so mum usually would offer from her hands (*sounds of writing*) rather than the container (3) and maybe if I'd asked her that first- well no cos its always useful to see
15:08 (TCHR_7) yeah [LOSING OPPORTUNITY TO GIVE CHILD A VOICE (OC)]
(CHR05\05_PostADOS: 367-370)
- viii** 07:27 (SpHV) there was no following my eye gaze there was no reco- he didn't [look at your face to]
07:30 (TCHR_7) [he didn't look at you] to. .hh .hh
07:32 (SpHV) look no no
...
09:08 (SaLTee) when the bubbles were finished he looked up to you as he looked up (...)
you would bring more [REVEALING CHILD BEHAVIOURS AS POTENTIAL OUTCOME CONTRADICTION (OC)]
(CHR05\05_PostADOS: 188-190;230)
- ix** 01:08 (EP) Well (.) she did it on that we- an it is talking(...) this bit is focused on the use of the rabbit (1)
(st) so(...) if we be kind
01:18 (EYPrac) Mm mm
01:19 (EP) because she did do it then
01:20 (EYPrac) yeah [TAKING A DEVELOPMENTAL BENEVOLENT POSITION (OC)]
(CHR03\03_PostADOS: 258-261)
- x** (SpHV) .hh he's quite vocal and able he's been seen by speech therapy and discharged from them becoss
01:02 (Paed) [Mm]
01:03 (SpHV) [actually] his speech is coming along .h but it is≈ all the social side of things(...) [WEIGHING UP CONFLICTING VERSIONS OF CHILD CAPABILITIES (OC)]
(CHR04\04_PreAssmnt: 25-27)
- xi** 04:05 (EP) But still (1) ok functional play? (1) she would do this(.) but again(1) that(...) no she did do that spontaneously
04:17 (EYPrac) She did she said
04:17 (EP) An when I said its a little baby she made it into a smaller- [she did] haha
04:21 (EYPrac) [she did] but again it was it was prom- it was- you were mo- prompting again weren't you encouraging her all the way an it was continuous she was happy to do it but it needed that- [COUNTERBALANCING +VE ABILITIES WITH -VE ABILITIES (OC)]
(CHR03\03_PostADOS: 320-323)

Following the Centre-based ADOS assessment, after establishing a ‘*cut-off*’ score, the Keyworker (*conduit*) arranged for the paediatrician (medical perspective) to provide official confirmation of a diagnosis:

i (SpHV) .hhh (1) we’ve seen (CHR04)(2) done an ADOS(.) he meets cut-off(.) on the ADOS
 00:12 (Paed) mm
 ...
 [but they have]
 00:47 (Paed) [mm hm]
 00:47 (SpHV) indicated he(.) does seem to be presenting features
 00:49 (Paed) Oh dear .hh

[BRINGING TO ATTENTION OF PAEDIATRICIAN TO CONFIRM DIAGNOSIS (FC)]
 (CHR04\04_PreAssmnt: 5-6; 17-20)

4.3.2. Section Summary

This section described the active processes revealed in professionals’ discussions. An open-door referral system filtered incoming requests for specific diagnostic assessment of child difficulty. After the initial filtration, a Centre-based Keyworker used sifting, sorting and filtering of gathered information, together with the standardised ADOS assessment to make a clinical decision. A diagnosis constituted the child outcome.

In the next section, facets of the talk pattern in professional use during the referral system for the specific child cases are presented.

4.4. KEY FINDINGS: TALK PATTERNS

Analysis revealed significant descriptors for the patterns of talk used by professionals, and illustrated the interactive nature of their work. Talk featured *individual contributions*, demonstrating hierarchical forms of relations. Paired or group exchanges featured forms of

punctuated talk and *mirroring* of child attributes and the perspective of the work. Talk also consisted of *easy exchanges* and comfortable agreement in the form of *echoing*. Disbelief, or a resistance through non-negotiation meant alternate views or difficult, *frictional decision-making* was suspended.

Explanation follows for these features, with text exemplars to support findings.

4.4.1. Individual Contributions

Professionals made influential comments, as *direct* or *indirect* discussion contributions. Indirect responses were *unchallenging* or un-pressurising phrases, in which the speaker presented an *easy-going* agreement:

-
- i** 01:04:47 (M) I can't remember him at all I'm being honest
01:04:49 (SLT) Ok. that's fine erm (2)
- [UNCHALLENGING (FC)]
(CHR04\04_Panel_1: 27-28)
- ii** 01:05:52 (EP) Yeah] s'no rush
- [EASY-GOING-NOT A PROBLEM/DON'T WORRY (OC)]
(CHR04\04_Panel_1: 52-53)
- iii** (TCHR_4) That's Ok] (.)it's just erm
02:14:57 (SLT) Yeah jus she's not been [allocated an appointment yet
[LEADING TO A DELAY FOR THIS CHILD [OC]
- 02:14:58 (TCHR_4) Yeah] that's fine that's ok.
02:15:00 (SLT) OK?
02:15:01 (TCHR_4) That's ok. Can I check for a couple of my families if that's ok...
- EASY-GOING-NOT A PROBLEM/DON'T WORRY (OC); CONCERNING OWN WORK PRIORITIES (OC)]
(CHR03\03_Panel_3: 42-46)
-

This response style during discussions was often in the form of *echoing* and was considered proportionate to the status of the speaker. Early Years practitioners, teachers or trainees supported the Keyworker assessment position. Likewise, the Keyworker similarly deferred to those in higher position¹¹, for example the Paediatrician/Centre Manager.

i	08:07 (SpHV) I did think he got the cause and [effect] by pressing it 08:08 (SaLTee) [cause an effect]yeah the [cause n effect]	[ECHOING (OC)] (CHR05\05_PostADOS: 211-212)
ii	04:43 (EP) But I found her very difficult [to understand] 04:45 (EYPrac) [difficult to understand] yep	[ECHOING (OC)] (CHR03\03_PostADOS: 70-71)
iii	08:39 (SpHV) so now the bubble play. (1) he enjoyed bubbles 08:42 (TCHR_7) he did yes he did 08:43 (SaLTee) mm 08:43 (SpHV) [he did enjoy] the bubbles 08:44 (SaLTee) [yes he did]	[ECHOING (OC)] (CHR05\05_PostADOS: 218-222)

Indirect contributions were as forms of response in the background by those potentially in lower status positions, thought to carry a strengthening, encouraging effect on those appearing to make the decisions.

i	(SLT) <u>diagnosis done</u> (<i>pats table</i>) 21:50 (TCHR_1) Mom's very very very anxious (1)	[MAKING EARLY DIAGNOSIS FROM NATURE OF LISTED CONCERNS (OC)] GIVING AFFIRMATIVES (ENCOURAGING) (OC)] (CHR02\02_Panel_1: 32-33)
ii	(SLT) He is rigid in his need for routine and has obsessive behaviours around [Thomas the tank engine 21:28 (TCHR_1) Mm, he does...]	[GIVING AFFIRMATIVES (ENCOURAGING) (OC)] (CHR02\02_Panel_1: 30-31)
iii	(Paed) which I know is- is [difficult](1) 00:28 (SpHV) [ye:s̃] (2) [ha ha] (3) [difficult yeah] ... 00:33 erm .hh (2) ... erm although she said it's got <u>worse</u> now it certainly wasn't [very good today in any way erm] 00:58 (SpHV) [its not good no no] it isn't good	[ADDING WEIGHT/ ENCOURAGING (OC)] (CHR04\04_PostAssmnt: 10-13)

Where individual contributions were more direct, many of these were coded as *assertive* when a lead figure used a firm position to give direction, overrule or weigh up a particular point:

i	30:32 (EP) So at this stage we're saying refer [to- 30:35 (SLT) <u>Close.</u>] 30:36 (EP) [we're closing? 30:36 (SLT) <u>Close.</u>]	[OVERRULING (OC)] (CHR06\06_Panel_1: 37-40)
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ii	(SpHV) so its 19 takes us well over cut-off. cut off is 12 24:30 (SaLTee) ohhh 24:31 (SpHV) [for interaction] cut off was 7 an he got 13 so he's well over cut off. carry on 24:36 (SaLTee) c1	[DETACHED (OC)] (CHR05\05_PostADOS: 578-581)
iii	22:43 (SLT) Right] 22:45 (TCHR_1) and containment she was brilliant 22:45 (SLT) Right (1) ermm	[WEIGHING UP (OC)] (CHR02\02_Panel_1: 57-58)
iv	22:48 (SLT) Write] that down for us then 22:49 (TCHR_1) [ok 22:50 (SLT) Erm](...) put it on there as well so (.) [erm	[DEFERRING (TO AUTHORITY) (OC)] GIVING DIRECTION (OC)] (CHR02\02_Panel_1: 60-62)

Individually, professionals used *clustering* of terms, or *extreme case formulations*, as techniques that could add to a particular position, or emphasise their view to others:

i	(SpHV) when it's the right time we'll move in to an ADOS then when we move into the ADOS formally so the freeplay is part of the ADOS but when we then move into it erm	[CLUSTERING KEY TERMS FOR EMPHASIS (OC)] (CHR05\05_PreAssmnt_2: 142)
ii	(SpHV) did he give <u>anythink</u> to <u>anybody</u> at <u>any</u> point (1)	[STRENGTHENING POSITION THROUGH OVERSTATEMENTS (ECFs) (OC)] (CHR05\05_PostADOS: 461)
iii	06:03 (SpHV) He is <u>so</u> I've rarely seen <u>such</u> a <u>serious</u> little boy	[STRENGTHENING POSITION THROUGH OVERSTATEMENTS (ECFs) (OC)] (CHR04\04_PostAssmnt: 147-148)
iv	(TCHR_1) An and of the 7 parents on it] she <u>absolutely</u> got it(.)	[STRENGTHENING POSITION THROUGH OVERSTATEMENTS (ECFs) (OC)] (CHR02\02_Panel_1: 55)

The next section considers categories of talk patterns, which were less individualistic and found more particularly a *talk exchange* between two or more professionals. Transcribed data excerpts demonstrate how professionals continued to make *easy exchanges* and show hierarchical (*status*) differences.

4.4.2. Talk Exchanges

Patterns of talk indicated *hierarchical* status differences, or episodes in which professionals appeared to vie for positions of significance:

-
- i 06:40 (TCHR_7) .mm (1) they did know I was involved
 06:43 (SpHV) Yes so yeah (1)
 06:45 (TCHR_7) [I'd ima:gine they might] know you're involved
 [VYING INTERNALLY (SISSVCENTRE) OVER SIGNIFICANCE (OC)]
 06:48 (SpHV) [I'd- well well] it is on the computer system so
 BLUSTER (OC)
 (CHR05\05_PreAssmnt_2: 102-105)
- ii 06:35 (SpHV) ... but we will investigate that further and make sure that people know that we are involved
 (.).hh erm
 [BEING/FEELING LEFT OUT OF THE DECISION LOOP (OC)]
 (CHR05\05_PreAssmnt_2: 96-97)
- iii 01:14:46 (M) I told her I was a very busy person (1) an couldseeher in ½ an hour
 [CHOOSING WORK PRIORITIES; BEING IN A STRONGER POSITION (OC)]
 (CHR03\03_Panel_2: 56)
-

Professionals used a form of *punctuated talk*, where sentences were clipped, shortened, or unfinished. This was apparent when they seemed comfortably on each other's wavelength, or that they were interrupting/cutting across before another had finished speaking, through retaining their own line of thinking, or in stilted/stuttering, awkward speech.

-
- i 01:05:28 (M) But(.) apart from that I don't-
 01:05:30 (EP) So we'll accept-
 01:05:31 (M) remember this child (2)[atall
 01:05:34 (SLT) Right] erm so if we just(.)
 [OVERLAPPING EACH OTHER (OWN THOUGHTS/FOCUS) (OC)]
 (CHR04\04_Panel_1: 41-44)
- ii 29:55 (EP) Ermm(...) and also≈(...) [An I] (M) wi- pick it-
 29:55 (SLT) But I-]
 29:59 (EP) Because this is a- cos its an educa- y'know getting him in to≈
 [STILTED/STUTTERING; WITH AWKWARDNESS (MAKING A (GENTLE) CHALLENGE) (OC)]
 (CHR06\06_Panel_1: 25-27)
- iii 00:23 (SpHV) so if we~- I was ple::ased with how the appointment went (1) when [he arrived]
 00:26 (TCHR_7) [well I] thought he responded very well [with]- to you
 00:29 (SpHV) [yeah] yeah I thought that was [yeah]
 00:30 (TCHR_7) [yeah]
 00:31 (SpHV) he was ye::ah
 [UNFINISHING PHRASES-COMFORTABLE UNDERSTANDING EACH OTHER (OC)]
 (CHR05\05_PostADOS: 6-10)
-

This mode of expression was a particular feature of panel meetings, maintained by the core, professional triad (SLT, EP and M), who used *dissected* or *merging and mixing* forms of the punctuated talk, characterised as *two versus one*: A pair spoke together while the third reviewed their work aloud.

- i (SLT) ok. .hh(...) erm (1)so it's going to be that option but we need to (*keyboard clicking*)(1) complete.(...)
 01:06:05 (M) I didn't I looked on our da- on our database an [didn't] pick him up either
 01:06:07 (SLT) [Ok̄]
 01:06:09 (M) so that's weird (.)(2)
 01:06:09 (SLT) Ok̄~ (1) which might mean he's quite new?(1)
 01:06:13 (M) Mm [yeah] [MERGING AND MIXING TALK (OC)]
 (CHR04\04_Panel_1: 58-63)

- ii 01:17:21 (SLT) Ohh nohhh~ (high pitched)
 01:17:24 (M) What's the [matter?
 01:17:25 (SLT) I've just] me~ssed it up~ I put it on the- (2)
 01:17:28 (M) I've seen her aswell (*taps on table*)
 01:17:29 (EP) ok
 01:17:30 (M) Huh (1)
 01:17:31 (EP) Oh right that's (.) handy (1)
 01:17:33 (M) Saw her last week (2) let's get back to- (1)
 01:17:38 (SLT) (SLT)!
 01:17:39 (M) when it was (3) she (...)(*taps*) [needs (*taps*)
 01:17:45 (EP) I know] I've had everybody ringing me about her(...) It- its Mum's difficulties more than anything (1) ermm (5)(*writing sounds*)
 01:17:55 (M) Saw her last week I think [actually
 01:17:58 (SLT) Ohh dear] .hhh (5) (*writing sounds/ pen crossings out*)
 01:18:05 (M) Did I see her? (10) (*sounds of paper shuffling/ writing*)
 01:18:15 (SLT) made a mess of that one(3) can only get better (SLT)(1) right (2)
 01:18:24 (M) Saw her on the 5th of October (1) your s-(?) (SLT)
 01:18:27 (SLT) Oh sorry (3)
 01:18:30 (M) so I'll bring it back to panel next [time
 01:18:30 (EP) Ok] she's been referred before an-
 01:18:34 (M) Ohh my life
 01:18:36 (EP) we'll try an fix her at that date when got her on again anyway(...) erm (1)
 01:18:42 (SLT) Praps the paper work'll catch up with her then so this is ... [DISSECTING TALK OVER EACH OTHER (2 v 1) (OC)]
 (CHR06\06_Panel_2: 50-71)

In these panel situations also, core professionals had *easy exchanges* as paired, *comfortable one:twos* in their group situation.

i (SLT) So can you just help me with my copies
 45:52 (M) yep
 54:53 (SLT) So my referrer is Dr (name)(1)
 45:56 (M) GP is Dr (name)(...)
 45:58 (SLT) Thank you (2)
 46:01 (SLT) Erm (1) so we've got paediatrician
 46:04 (M) Yes speech therapy appointment made and [audiology
 46:07 (SLT) Yeah] .hh we we haven't got a setting yet have we?
 46:09 (M) Nope
 46:11 (SLT) Err and would you [like? (...)] a copy?
 46:14 (M) Mm hm] (2) Oh yes
 46:17 (SLT) Is that it then? Nobody else involved?(1)
 46:19 (SLT) Ok. Done. (*Taps table*) Thank you (2) [PAIRED DIALOGUES WITHIN GROUP TEAM (OC)]
 (CHR05\05_Panel_1: 35-48)

ii 01:58 (EP) Ok (2)
 02:00 (SLT) D'you want-
 02:01 (M) the yellowy [bits]
 02:01 (SLT) [I do] (*shuffling papers*)(2) doing doctor things
 02:05 (M) Ok≈
 00:06 (SLT) Yellowy [bit]
 02:07 (M) [Yellowy] bit
 02:08 (SLT) and- oh(2) s-
 02:10 (M) Yellowy bits already bin there [COMFORTABLE ONE-TWOS (OC)]
 (CHR06\06_Panel_3: 27-35)

A further feature of professionals' language expression was *mirroring* attributes of child descriptors:

i (SLT) ... speech≈ dela:y(...) and communication delay and no eye contact no pointing no smiling(1) .hh fascination with spinning washing machines bicycle wheels [.hh [MIRRORING DESCRIPTION OF CHILD ATTRIBUTES (FC)]
 (CHR05\05_Panel_1: 15)

ii (SpHV) no::body got any response to [name did they]
 07:05 (TCHR_7) [no no]
 07:06 (SaLTee) [no yeah]
 07:06 (SpHV) so neither of your nor mum
 07:07 (SaLTee) nor mum no yeh
 07:08 (SpHV) no response at all an an and you see absolutely no change to his facial expression
 07:13 (TCHR_7) no
 07:13 (SaLTee) no
 07:14 (SpHV) there there's nothing
 07:15 (SaLTee) no
 07:15 (SpHV) its as if nobody's said anything at all
 07:16 (TCHR_7) no recognition at all
 07:17 (SpHV) nothink at all to family or to facilitator (2) [MIRRORING DESCRIPTION OF CHILD ATTRIBUTES (FC)]
 (CHR05\05_PostADOS: 174-186)

Professionals made repeated use of non-verbal sounds, sniffs, sighs or yawns, which were interpreted as significant, as well as frequent reference to the term repetitive and adopting strategies that appeared to depersonalise the child:

i	21:20 (SpHV) none. (3) unusually repetitive interests or stereotyped behaviours. now he was a bit repetitive if he liked something wasn't he it was a bit repetitive I thought with the rabbit (1)	[...REPETITIVE...(OC)] (CHR05\05_PostADOS: 514)
ii	(SpHV) we were ((<i>sniff</i>)) unable to proceed	[SNIFFS/SIGHS (OC)] (CHR05\05_PreAssmnt_1: 133)
iii	(EP) referred from SI~SS (4) 01:03:33 (SLT) ((<i>sigh</i>))	[SNIFFS/SIGHS (OC)] (CHR04\04_Panel_1: 5-6)
iv	(SpHV) ((<i>yawns</i>)) we're going to do (CHR05)	[DEPERSONALISING CHILD (OC)] (CHR05\05_PreAssmnt_1: 9)
v	45:32 (M) Who's having that one?.hh (1.5)	[DEPERSONALISING CHILD (OC)] (CHR05\05_Panel_1: 29)

In situations of *differing opinion*, professionals held their ground individually, with the conflicted topic appearing as *suspended*. The lead professional (Keyworker/Centre Manager) provided the final say if a decision occurred.

i	01:17 (SaLTee) well (.) bu- when th- when they arri::ved 01:19 (SpHV) yeah 01:20 (SaLTee) mum come in and sit down and (CHR05) was over the::re 01:22 (SpHV) mm hm 01:22 (SaLTee) its only when mum said $\bar{o}h$ $\bar{h}e$ $\bar{t}hr\bar{e}w$ $\bar{h}i$ - he threw upon hisself thas. that when he [came back to mum] 01:27 (SpHV) [to to co- to] clean it [up yeah] 01:28 (SaLTee)[otherwise he was] already over there 01:29 (SpHV) you think he [might have stayed] 01:30 (SaLTee) [yeas] yeah ha ha 01:32 (SpHV) ye:ah ha ha [but then having-]	[CONFLICTING OVER INTERPRETATION OF CHILD BEHAVIOUR/NEEDS (OC)]
	01:32 (TCHR_7) [I though- now] now I sa- saw that differently	
	01:35 (SaLTee) mm (SpHV) mm	
	01:35 (TCHR_7) I(.) saw him(.) a bit agitated and [$\bar{e}r\bar{h}$ $\bar{e}r\bar{h}$]	HOLDING OWN (OC)
	01:39 (SpHV) [yeah] mm hm and then he wanted that[comfort from her]	
	01:40 (TCHR_7) [yeah yeah]	
	01:42 (SaLTee) $\bar{h}m$	LEAVING IT SUSPENDED (OC)] (CHR05\05_PostADOS: 27-43)

<p>ii (TCHR_1) I'm questioning an alternative provision. 02:03 (SpHV) [yeah] (9) (<i>sounds of writing</i>) lets score (.) ados</p>	<p>[LEAVING IT SUSPENDED (OC)] (CHR06\06_PostADOS: 20-21)</p>
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Professionals responded to points of view alternative to their own, as a tendency to disbelieve or take a non-negotiable stance, which had the same effect in suspending discussion.

<p>i 01:48 (SpHV) [but] while he was snuggly with her~ he was actually giving me eye contact 01:53 (TCHR_7) he was [an I couldn't see] 01:53 (SaLTee) yea:: yea:: 01:54 (SpHV) yeah rea::lly were surprised 01:55 (TCHR_7) its incredible. 01:55 (SaLTee) he di- he di- 01:56 (SpHV) yeah it it he di- which wa- was a huge surprise 01:59 (TCHR_7) [yeah] 01:59 (SpHV) [yeah] 01:59 (TCHR_7) because he doesn't. 02:00 (SpHV) ye- no: so maybe that's something an area that he's improving on- anywa- 02:04 (TCHR_7) could be(.) yeah</p>	<p>[DISBELIEVING ALTERNATIVES (OC)] (CHR05\05_PostADOS: 48-59)</p>
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4.4.3. Section Summary

This section described the nature of talk exchanges coded from professionals' discussions for these particular child cases. Low status professionals either used indirect, individual comments as a form of easy-going support, or made background contributions of influence. Contributions of higher-status professionals were firm and overt.

Professionals group talk exchanges were punctuated, with patterns of dissected, merging and mixing, or comfortable exchanges noted. Leaving conflict suspended, mirroring of child attributes, depersonalisation and the use of non-verbal sounds also featured.

With the active processes of the professionals' operation of the referral system and assessment 'pathway', and the interactive elements of their featured talk, analytic descriptions showed that

professional decisions likely occurred in relation to expectations of system maintenance, from which a cyclical array of effects were considered.

The open door policy, thought to bring high referral numbers created a ‘conveyor-belt’ effect, which combined with professional absences, time limitations and NHS targets (official outcomes measures), placed pressure on professionals. Such system pressures, with perceived avoidance functions revealed from language patterns, appeared to affect decision-making processes.

4.5. DECISION-MAKING PROCESSES: REFERRAL SYSTEM

The referral system was characterised by an open door policy, ‘conveyor-belt’, high numbers, absenteeism and ‘clock ticking’. Professionals made expedient decisions as they engaged with these system requirements. The components of this conceptual position were *weighing-up* and *sifting, sorting and filtering*, maintaining *centralisation* and *convenience*, and *continuation* for system functions, despite problematic eventualities.

4.5.1. Expediency

Professionals managed incoming information by attending to salient aspects of child detail in panels during the limited time available. Reading specific details (referrer status, level of child symptomology, previous family history for ASD) to *weigh up* the most significant aspects whilst also attending to the extent of parent concern, enabled *filtration* of high numbers. The Keyworker’s use of sifting, sorting and filtering (*weighing up*) relevant diagnostic information during ADOS supported its significance as a key tool in assessments. High referral numbers created pressure in terms of responding to NHS target requirements. Professionals adopted

compensatory, *convenience* practices as a potential means of maintaining the system and a sense of control. Professionals adopted expedient options, for example, ‘cutting corners’ to some processes.

-
- i 01:25:44 (SLT) Erm(.) normally I would ask for indicators but (EP) and I are gonna work on thresholds and indicators so because it's now ¼ to one(...) I'm going to say [relax-
[DECIDING TO FOREGO ANY FURTHER DISCUSSION (OC); TAKING LEAD IN DIRECTING PROCESSES (OC)]
(CHR03\03_Panel_2: 47-48)
- ii 01:14 (SpHV) we have(.) seen (CHR02) in here at the centre for a variety of standardised assessments including the ADOS and a Bailey's Developmental Scale
01:24 We've also had questionnaires completed by mum(.) erm sensory profile questionnaire a Bailey's adaptive scale questionnaire
[THROUGH FORMAL STANDARDISED INSTRUMENTS (OC)]
(CHR02\02_PostAssmntSummary: 15-17)

Key professionals (the core Centre team and specialist Keyworker) found it helpful to maintain a *centralised* position: this limited time away from the Centre. This was possible where liaison with others allowed their experiential views and knowledge of the child to be gathered. Early Years professionals were preferred for conducting the home visit, which served to facilitate initiation of assessment processes through questionnaires left with the parent. The child and parent came to the Keyworker at the Centre for the ADOS assessment.

-
- i 02:24 (TCHR_1) ... there's certainly some- differen- difficulties there and erm- I thi- don't- I'm not sure how much mum is able to understand of the letters that are sent out so I do [think that]
02:36 (SpHV) [ohh ri]
02:37 (TCHR) whatever appointments we send out that we back up with a [phone call]
02:40 (SpHV) [yeah]
02:40 (TCHR_1) to make sure she's understood
[MINDING THE PARENT (OC)]
(CHR06\06_PreAssmnt: 18-22)
- ii 00:26 (SpHV) So this is our s- 3rd time ha of meeting ha erm (TCHR_7) and myself ha in order to t- waiting for (CHR05) to arrive for an appointment the previous two appointments he hasn't arrived (.) so (.) this is our third time? third timelucky
[FRUSTRATION OVER PARENT ATTENDANCE (OC)]
(CHR05\05_PreAssmnt_2: 7)
- iii 06:34 (SpHV) and when speech therapy have seen him
06:35 (Paed) Yeah
[USING INFORMATION FROM OTHER PROFESSIONALS INFLUENTIALLY (OC)]
06:35 (SpHV) they've also said although they're not concerned abouthisunderlyingspeech, social skills are [not there]
06:38 (Paed) [Mm] COUNTERBALANCING +VE ABILITIES, WITH -VE ABILITIES (OC)
(CHR04\04_PostAssmnt: 171-172)
-

The theme of absent MDT professional, featured in panel meetings for particular children prevailed also in these child assessments. The absence of a social care perspective was evident across the immediate assessment ‘pathway’ phases for these particular children. When the research began and a social worker was present at a panel meeting, this position was withdrawn in the latter phases of the research (see Appendix 7.4.5, p. 230). Professionals managed such unforeseen absences by adopting system *continuation* practices.

-
- i (SLT) We’ve lost (SWkr) now
 +10:50 (EP) (leaves room (*parent has turned up when thought cancelled*))
 (SLT) Ok ha ha(.) jus me an you now (name)
- [ABSENT PROFESSIONALS (OC);
 UNEXPECTED EVENTS/ISSUES – CONTINUATION & ADAPTATION (FC)]
 (CHR03\03_Panel_2: 14-16)
-
- ii 03:54 (M) Mm hm(2) yep mm hm hm now put those together (4) oh god.
 04:05 (SLT) That noise is really driving me ma::d (2) it’s better in this room though than in- than in a room with a child
 04:14 (M) Yeah that’s true
- [EXTRANEIOUS, BACKGROUND INTERFERENCE (OC)]
 (CHR06\06_Panel_3: 61-63)

System maintenance continued with apparent shortcomings of information. Although assessment limitations (no contextual, setting data) and safeguarding concerns were emphasised in discussions about some children, the ADOS assessment and ensuing diagnostic decision continued.

-
- i 01:50 (SpHV) Ok that’s fine now 1 to 6 lovely (...) D’ye know how he’s getting on there
 01:56 (TCHR_7) (...) No
 01:57 (SpHV) ok
 01:58 (TCHR_7) Not really a r o it’s on- it’s on my list [to- to go] in an see(.) see ‘im
 02:03 (SpHV) Right]
 02:04 (TCHR_7) In the next couple of weeks
 02:06 (SpHV) brilliant (..) [RESTRICTED INFORMATION (OC); FROM LIMITED/NO TIME WITH CHILD (OC)]
 (CHR05\05_PreAssmnt_1: 57-63)
-
- ii (SpHV) (...)ok. so we’ll we’ll try an investigate that and find[a little bit] more information
 05:58 (TCHR_7) [yes]
 05:59 (SpHV) I imagine if he has been put on the child protection register that’s usually under the category of emotional (1) because of the (.) domestic
 06:07 (TCHR_7) yeah yeah
 06:09 (SpHV) abuse from within the family but we will check that out and see so we do obviously need to get more information about that [HAVING TO GUESS OVER THE DETAIL (OC)]
 (CHR05\05_PreAssmnt_2: 88-92)

-
- iii 07:49 (EP) (...) we saying- have we checked(...) we haven't got a [speech therapy
 07:55 (EYPrac) [No I was gonna have a look at that-]
 07:56 (EP) referral have we?]
 07:56 (EYPrac) No we need to chase that up
 [CONTINUING WITH INCONSISTENCIES/MISSING INFORMATION (OC)]
 (CHR03\03_PostADOS: 386-389)
-

The paediatrician maintained conveyance of an ASD diagnosis to CHR04's mother when discussion of reported physical symptoms and a last minute revealing of potential other (not previously discussed) medical symptoms could serve possibly to confound decision accuracy.

-
- i (Paed) (she didn't mention [about the gaviscon and the reflux]
 01:43 (SpHV) [Nooo noo I know I've just thought] about that just realised that
 01:47 (Paed) Ermm but that's something I can I can raise wi-[wi-] with
 01:50 (SpHV) (name)
 01:51 (Paed) (n- name)
 01:51 (SpHV) mm yes thanks (Paed)
 [CONTINUING WITH INCONSISTENCIES/MISSING INFORMATION (OC)]
 (CHR04\04_PostAssmnt: 26-31)

- ii (07:03 (SpHV) .hhh and she didn't mention(2) absences to you did she?
 07:06 (Paed) No
 07:07 (SpHV) No ok (1) ok
 [REMEMBERING, LAST MINUTE POTENTIALLY SIGNIFICANT DETAIL (OC)]
 07:09 (Paed) Erm that is just something- (2)
 07:11 (SpHV) Bu- er I think it's probably just him tuning ou::t
 07:13 (Paed) Yes I think I mean quite a lot of autistic [children do]
 07:15 (SpHV) [Yes]
 [JUSTIFYING, EXPLAINING AWAY, POSSIBLY SIGNIFICANT DETAIL (OC)]
 (CHR04\04_PostAssmnt: 189-191; 192-195)
-

This section showed how perceived pressures of system maintenance influenced the decision-making of professionals with findings for expediency, including centralisation and convenience. Aspects of decisions also entailed continuation of functions, although problematic events or absences could occur.

In the next section, findings for the influences of avoidance functions in the decision-making processes of professionals are reviewed.

ii	04:05 (SpHV) corners (2) <u>mum said</u> did somebody write that down? that at home (.) he'll jus go an stay sit or stand in a place an not do anything just be in it	[CONFIRMING MOTHER'S VIEWPOINT (OC)] (CHR05\05_PostADOS:114)
iv	05:23(SpHV) .hh parents are seeing lots of difficulties at home nursery are not seeing the same demonstration of difficulties in nursery .h don't think it's fair to absolutely rule autism out the same point we cannot give a diagnosis because he does not meet ICD 10 classification	[WEIGHING UP CONFLICTING VERSIONS OF CHILD CAPABILITIES (OC)] [SEEKING NOT TO DISAPPOINT PARENTAL EXPECTATIONS (OC)] DIAGNOSING ON THE BASIS OF NUMERICAL SCORE (OC)] (CHR02\02_PostAssmntSummary:35)

4.6.2. Abandonment

Analyses revealed a sense of abandonment experienced by professionals in their diagnostic task, which led to 'draw[ing] in' outside individuals, whilst the nature of their work served to attract trainees for experiential development.

Talk indicated that the experience of Centre professionals was overlooked outside the Centre. This reflected too in key professionals not involved in immediate assessment discussions (see pp. 89, 112).

i	06:20 (SpHV) But we'll- do they know he's been referred to the (name) centre? (...) they should know 06:24 (TCHR_7) They should know bu I-	[COMPLAINING FOR BEING OVERLOOKED OUTSIDE OF CENTRE (OC)]
	06:25 (SpHV) I'm very surprised- we would normally have been told (SaLTee) 06:28 (SaLTee) mm hm	BEING/FEELING LEFT OUT OF THE DECISION-LOOP (OC)
	06:28 (TCHR_7) I wasn't [told either I found out by chance] 06:30 (SpHV) [but (TCHR_7) found out by chance] yeah. so this is(.) not good that we havent didn't know bout this but 06:34 (TCHR_7) no (...) joined up [working] huh	RECEIVING SHORT/ POOR NOTICE FROM OTHER PROFESSIONALS (OC)] (CHR05\05_PreAssmnt_2: 94-97; 98-100)
ii	25:04 (SpHV) absolutely what em what I'll do now (1) is bring him back (TCHR_7) did you want to join us for that (SaLTee) I don't know if you're around or not 25:12 (SaLTee) what day is it 25:13 (SpHV) was it was it a monday 25:14 (TCHR_7) a monday. No	[PRESSING TO BRING ADULTS BACK TO THE CENTRE (OC)] (CHR05\05_PostADOS: 595-598)

Professionals used *humour* to deflect in the management of more awkward situations, possibly to defend against uncomfortable difficult decisions, or as wry joke about the child's abilities. This was also noted in talk depersonalising the child.

i	01:44 (TCHR_7) so em I dunno that now ha ha ha 01:45 (SaLTee) ha ha ha (...)	[BREAKING AN ATMOSPHERE (OC)] (CHR05\05_PostADOS: 44-45)
ii	00:50 (EYPrac) The very little language generated reflects ha ha how much I've got written ha ha down cos I usually gorra lot more (1)	[WRY LAUGHTER/JOKE (OC); OVER CHILD ABILITIES (OC)] CHR03\03_PostADOS: 9
iii	02:12:04 (TCHR_4) I don't know she's jus said [check 02:12:06 (SLT) Ha ha ha] 02:12:07 (TCHR_4) check ha ha 02:12:07 (SLT) What are we [checking 02:12:08 (TCHR_4) ha ha ha ha ha] 02:12:09 (SLT) Yeah give us a clue (M)	[COVERING UP (OF LACK OF DETAIL)(OC)] (CHR03\03_Panel_3: 10-15)

Routine contributions of professionals to system maintenance were perceived as *adopted roles*. These were evident from interpretation of the represented actions and dialogues taken in the work conduct. Standard (dictionary) form characterise these researcher constructions.

Such interpretation developed from coded dialogues showing work positions were apparent throughout discourses during system conduct.

Professionals outwardly identified with particular system role titles, than specify their individual field specialism:

i	(SLT) er I'm (name)clinical lead at (name) centre 00:17 (M) (name) from the under 6 team at SISS 00:20 (SWkr) and (name) urm from(.) the children's disabilities team 00:25 (EP) (name) under 6 team lead	[DEFINING ROLE TITLE (NOT OWN PROFESSIONALISM) (OC)] (CHR03\03_Panel_2: 8-11)
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4.6.3. Professional Adopted Roles

The positions adopted during this team's work appeared to bolster routine, co-ordination and predictability during system maintenance.

Evident roles include controller, guardian, pacifier, bystanders-absentias-absconder and the mother figure.

The '*controller*' – 'A person or thing that directs or regulates something; a person in charge...' (OED, 2010).

The Centre Manager (SLT) routinely held the position as reader of the child's referral detail during panel meetings; this was on occasion, offered to the SISS Manager (M). Dialogues reflected this position as the system leader, recording the detail of decisions, constructing acknowledgement letters, and directing decisions that required particular consideration, often with emphasis regarding target expectations.

-
- i** 02:02:27 (SLT) I need [urgently to know
02:02:28 (TCHR_4) You need to ask (M)] [Ok.
02:02:29 (SLT) So] it's (CHR04)(2) err date of birth (*Writing sounds*) 6 3 10 (2) We need to going to know when the home visit was done(2) and(.) (M)'ll know what we mean(.) if we need to do another home visit(1) Ok. (*Writing sounds*) (5)
[DISSEMINATING TASKS(OC);MAKING THE WRITTEN RECORD OF DECISIONS [OC]]
(CHR04\04_Panel_2: 7-10)
- ii** 02:46:16 (SLT) ... just let me finish the letter an then I'll summarise it so the letter that the parents are receiving will say
[SCRIPTING LETTERS TO BE SENT DENOTING CENTRE INVOLVEMENT (OC)]
(CHR06\06_Panel_3: 46)
- iii** 01:03:35 (SLT) ThanQ So this one (M)?(.) do youwannadothis one?
[CONFERRING READING-OUT TO COLLEAGUE (OC)]
(CHR04\04_Panel_1: 8)
- iv** 19:29 (SLT) ok (1) right (1) only child of (name) and (name) lives with father's extended family(.)
[READING OUT THE REFERRAL INFORMATION (OC)]
(CHR02\02_Panel_2: 39)
- v** 32:53 (SLT) OK(...)(*shuffling paper/ writing sounds*) (15) So there I'm putting on the yellow form closed awaiting (1) paren- parents to complete referral form (4) (*mouse clicks*)
[NOT ACCEPTING (OC);UNABLE TO PROCEED WITHOUT PARENT CONSENTS (OC)]
(CHR06\06_Panel_1:54)
-

The '*guardian*' – 'A person who protects or defends something...who is legally responsible for the care of [one] unable to manage their own affairs' (OED, 2010).

The Under-6 Team Lead (EP) was the individual who 'minded' the data, entering key information to the spread sheet. This gave the overview to the numbers and ages of the referrals and potential means to question the emerging patterns. Dialogues from this position heard developmental and/or educational considerations given toward a child.

i	27:54 (EP) Thi- this is a lot referrals for this time of year	[INSPECTING NOTICING SPREADSHEET PATTERNS (OC)
	27:57 (SLT) It is I was(.) really hope there were- that there's jus be 3 or 4 today oops [done that-	AND NOT REALLY LISTENING (OC)
	28:01 (EP) Well] there are zero um(..) I'll talk to you another time about erm (??) (<i>paper's being shuffled</i>)	DEFERRING NEED TO DISCUSS EMERGING PATTERNS (OC) (CHR06\06_Panel_1: 3-4)
ii	(SLT) so the plan includes referral to SISS (1) and assessment at the (name) centre with an ASD focus. (3)	[PROCEED TO FULL ASSESSMENT (OC)
	21:20 (EP) I'd say he's only~ [only 18 months] (.) he's little	SEEING THE CHILD AS TOO YOUNG FOR DIAGNOSIS (OC) (CHR02\02_Panel_2: 46)
iii	01:26:35 (EP) yeah so we done with the(.) spreadsheet	
	01:26:38 (SLT) [Yes thank you	[MINDING THE SPREADSHEET (OC)]
	01:26:38 (M) Yes I have]	(CHR03\03_Panel_2: 61-64)

The '*pacifier*' – 'A person or thing that pacifies someone or something; quell anger, agitation or excitement of, or bring peace...' (OED, 2010).

Friction could be apparent between the Centre Manager (SLT) and the Under-6 Team Lead (EP):

i	30:14 (EP) Yeah I'm] just wondering whether you want to give her just a ca:ll (<i>scraping</i>) to explain it as we:ll <u>ok</u> .	
	30:19 (SLT) (<i>heavy pen scraping x3</i>) Work this out(.) date(.)	[SIGNIFICANT SOUNDS (OC)
	30:22 (EP) <u>ok</u>	FRICTIONAL DECISION-MAKING; CLASH OF WILLS (OC) (CHR06\06_PANEL_1: 33-36)
ii	28:27 (SLT) <u>Ok s'</u> here's yours (EP) (<i>paper's being shuffled</i>) o:k(.) GP referral again	
	28:33 (EP) (?)that's right	
	28:34 (SLT) That's really unusual	
	28:36 (EP) Ah ha	
	28:36 (SLT) Maybe it's because schools aren't in business	
	28:38 (EP) Maybe(.) s' not the 12th is it it's the 14th	
	28:41 (SLT) 14th I'm putting.	[SAFE TALKING (FC);
	28:44 (EP) Umm I've just written it 3 times s' al ri:ght	MASKING AWKWARD DIFFERENCES (OC);
	28:47 (SLT) Ha Ha Ha (...) <u>right</u>	NOT REALLY LISTENING TO EACH OTHER (OC) (CHR06\06_PANEL_1: 16-24)

The SISS Manager, (M), in adopting a more neutral position, acted to ‘keep peace’, often using a conciliatory tone towards the Centre Manager (SLT).

i	(SLT) Are you signing for [(EP)?] I’m not- I’m not passing many to (EP)	[COUNTERSIGNING ON BEHALF OF EACH OTHER (OC)
	43:51 (M) [yeah] Yeah I am	PRAISING (OC)
	43:53 (SLT) Good. Well [done.	
	43:55 (M) She’s my [friend ha ha]	
	43:55 (EP) [Ha ha]	AS FLATTERY (OC)]
	43:56 (SLT) [ha ha] Right	(CHR05\05_Panel_1: 8-9)
ii	01:14:46 (M) [Well I’ve got the referral] <u>anyway</u>	
	...	
	01:15:03 (M) shall I look- I haven’t given] them a date yet cos I only did it yesterday [so I’ll find you one now]	
	01:15:06 (SLT) [If you could have a little route] that’ll be helpful	[BEING AN INTERMEDIARY (OC); DIFFUSING/SOOTHING OVER AWKWARD SITUATION (OC)]
		(CHR06\06_Panel_2: 15;21-22)
iii	03:40 (SLT) Ok yes actually that’s true its the <u>only</u> example we didn’t have	
	03:43 (M) Didn’t do bad though we done <u>everything</u> else	[DIFFUSING/SOOTHING OVER AWKWARD SITUATION (OC);
		SMOOTHING OVER BLIPS IN THE SYSTEM (OC)]
		(CHR06_06_PANEL_2:6)
iv	01:14:47 (M) So I’m happy to do] it yep (1) so school have referred to <u>us</u> so (1) if you’re happy with that (SLT)?	
	01:14:54 (SLT) Very happy with that ha ha	[USING DEFERENCE TOWARDS MANAGER (OC)]
		(CHR06\06_Panel_2:17-18)

‘Bystanders’ – ‘A person who is present at an event or incident but does not take part; an observer or spectator’ (OED, 2010).

Here, there were observers of the processes taken by the core Centre team, with dialogues found providing humour, encouragement or influence on decisions towards the system’s apparent, uncovered, particular purpose to diagnose the child.

i	01:06:14 (SLT) Thank you] you’re doing a great job there ha ha ha	[REMEMBERING A.N.OTHER PRESENCE (OC)
	01:06:15 (TCHR_2) Ok ha ha ha.	
	01:06:16 (SLT) Just ignoring you(.)dear	FROM EMBARRASSMENT (OC)
	01:06:17 (TCHR_2) Oh [that’s <u>fine</u>	EASY-GOING – NOT A PROBLEM/DON’T WORRY (OC)]
		(CHR04\04_Panel_1: 65-67)
ii	(SLT) erm mum er (.) is very anxious but was (.) excellent to work with	
	23:20 (TCHR_1) [she was	[BACKGROUND CONTRIBUTING; GIVING AFFIRMATIVES (ENCOURAGING) (OC)]
		CHR02\02_panel_1: 64-65)

-
- iii 03:37 (EYPrac) But you did you you were [continuously prompting-]
 03:40 (EP) [That- that's what that's a key bit] there isn't it
 03:41 (EYPrac) You were continuously [weren't you]
 03:43 (EP) [Continuously] modifying
 03:45 (EYPrac) That's what I would say it was continuously modifying
 03:46 (EP) Mm yeah [ADDING WEIGHT/ENCOURAGING (OC)]
 (CHR03\03_PostADOS: 304-310)
-

'Absentias' – 'While not present at the event being referred to; *In absentia healthcare*: the provision of healthcare in the absence of a personal contact' (OED, 2010).

Professionals who were absent but contributed to these child assessments. In most instances, key absent professionals were social workers. Tertiary health professionals (OT, SLT, Physiotherapy) were also absent to assessment discussion, and liaised with Keyworkers.

-
- i (SpHV) .hh erm- actually needed to do quite a lot of liaison around (CHR02) but has largely been telephone liaison or written reports [KEYWORKER ACTING AS CONDUIT FOR OTHER INVOLVED PROFESSIONALS (FC)]
 (CHR02\02_PostAssmntSummary: 6)
-

'Absconders' – 'Leave quickly and secretly, or hides oneself, often to avoid arrest or prosecution' (OED, 2010).

The paediatrician's assessment contributions were positioned on the fringe of the system, where they were informed by the specialist Keyworker, when relevant, to confirm a diagnosis. Where they were unfamiliar with the case, the expertise of other professionals and the ADOS score were also used.

-
- i 06:24 (Paed) Yeah I think- I think if you say it meets ADOS
 06:27 (SpHV) Yeah [he does] he meets yeah
 06:28 (Paed) [he does](...) and the (name University) people ha-[were](.) concerned
 06:30 (SpHV) [Yeah]
 06:30 (Paed) Erm but there were features there [USING OTHERS' DECISION-MAKING (OC)]
 06:31 (SpHV) Yeah an that's what (.) [SISS feels] as well
 06:33 (Paed) [see how it goes] ACKNOWLEDGING VIEWS OF PROFESSIONALS KNOWN/LINKED TO CENTRE (OC)]
 06:34 (SpHV) and when speech therapy have seen him
 06:35 (Paed) Yeah USING INFORMATION FROM OTHER PROFESSIONALS INFLUENTIALLY [OC]
 (CHR04\04_PostAssmnt: 162-167)
-

Conversely, a mother could present as ‘too busy’ or distracted to attend reliably. This parent figure required ‘minding’ and bringing to the Centre, for example organising transport. This perceived in dialogues to reinforce the enduring nature of the professionals’ experience for the assessment task.

iii	00:26 (SpHV) third time lucky (TCHR_7) has done a bit of (...) background work and spoken to parents and reminded them and they have arranged transport today 00:50 (TCHR_7) Uh huh they have	[GOING EXTRA LENGTHS TO BRING PARENT/CHILD TO CENTRE (OC)] (CHR05\05_PreAssmnt_2: 7-8)
iv	04:25 (TCHR_1) ring her an offer it her an then I’ll put in my diary to prompt on tuesday an promp- or mm [monday] 04:26 (SpHV) [monday] 04:27 (TCHR_1) prompt again on wednesday 04:29 (SpHV) yeah yeah that’s [sorry yeah that’s [thursday- next thursday] 04:30 (TCHR_1) [so she’s here] on Thursday	[MINDING THE PARENT (OC)] (CHR06\06_PreAssmnt: 62-66)

4.7. CHAPTER SUMMARY

In this chapter, the findings of a mixed MDT interdependent referral system and child assessment ‘pathway’ were presented. The resulting theory describes processes used in professional decision-making.

Decision-making comprised of *System routines*, *Weighing-up* significance, *Expediency*, including *Centralisation* and *Convenience*, *Continuation of Function* and means of *Avoidance of Difficulty* and *Unpleasantness*. The ADOS ‘cut-off’ score was the main decision-making outcome here, used to diagnose children.

Implications of these findings are discussed in the following chapter.

CHAPTER 5: DISCUSSION

In this chapter, implications of the research are discussed in the context of the empirical literature. Methodological strengths and weaknesses are considered, as well as implications for practice and generalizability. The role of the EP in research and in MDT child assessments is discussed. Recommendations for future research are suggested.

5.1. SECONDARY REVIEW OF THE LITERATURE

Consistent with CGT methodology, a second literature review was conducted as data was gathered and analysed and initial concepts were formed, providing a more comprehensive view of emerging theory and lending credibility to the theoretical position in current research understanding (Charmaz, 2006; Urquhart, 2001).

Following is the literature¹³ on group and role behaviours, as well as relevant organisational and systems thinking approaches to work interactions. Recognition for anxiety effects within work is juxtaposed by outline of its contrast, productive work.

5.1.1. Team as Group

Bion (1961) characterised two group modes of mental function: basic assumptions or work-group mentalities, which have explained some of the difficulties inherent to integrated teams (Billington, 2006; Dennison et al., 2006; Ruch & Murray, 2011) and work/organisational group contexts (Armstrong, 1997; Brown & Starkey, 2000; Moxnes, 1998). Bion (1961) defines the

basic assumption group as an 'aggregation of individuals all in the same state of regression' (p. 142). Individuals have beliefs that the group has an "attitude" towards them, whilst the group has unconscious "attitudes" towards individuals and the group leader, influenced by the group's processes and behaviour (Granville, 2010).

Basic assumptions are thought to be highly developed in MDT groups (Stokes, 1994). *Fights for supremacy* in relation to the work or to the best, effective response to work problems, may mean members align with certain professionals or clients, according to different Bion mentalities (dependency, fight-flight, pairing), in order to strengthen their individual position (Stokes, 1994, p. 25). Such mentalities are described as defences against anxiety with *dependency* (BaD) when over-reliance is expressed toward the leader, or another idealised figure; *fight-flight* (BaF) as avoidant or confrontational responses when there is difficulty and *pairing* (BaP), as locating the 'problem' in a future event that can resolve the issues experienced (Bion, 1961).

Such mentalities purportedly diverge from the task aim, and cause group members unconsciously to shift their attention to another purpose, 'as-if in response to some unexplained impulse' (Bion, 1961, p. 188). The consequences of 'as-if' decisions is greater when motivated by unprocessed instinctual responses, somehow agreed without being aired or negotiated (French & Simpson, 2010).

Thematic analyses of social work practitioners' supervisory discussions has enhanced the understanding of individual and collective dynamics in integrated work practices (Ruch & Murray, 2011; Rustin & Bradley, 2008). The inclination of team professionals to avoid or 'take flight from' (BaF) anxiety and professional conflict made it difficult for social workers to act assertively (Bion, 1961; Ruch & Murray, 2011).

Analyses indicated that *mirroring* and *splitting* are significant dynamics characteristic of MDTs (Ruch & Murray, 2011). Mirroring is well-recognised in supervisory contexts, in which the dynamics of practitioner-family relationships might be reflected in the relationship between

practitioner and supervisor: 'the processes at work currently in the relationship between client and worker are often reflected in the processes between worker and supervisor' (Mattinson, 1992, p. 11). The social worker's role working with families to promote constructive inter-personal behaviour mirrored in relationships and experiences in integrated work with other professionals. A sense of parenting the professional system, comparable to their work with families, was evident, ensuring attendance and contribution: 'So it's our responsibility to ensure that every other professional is doing their job'; 'you can't make someone come into the conference can you... but that's what it needs to be...' (Ruch & Murray, 2011, p. 440).

'Splitting' (Klein, 1987) was seen in the experience of social workers. Splitting refers to the unconscious creation of good and bad parts of one's known objects (experiences, artefacts, relationships). This can keep separate and protect one's good aspects (necessary for personal survival) from the bad objects, thus retaining the freedom to attack such bad objects (Hutton, 1997). Concerns about information sharing prevailed. Other professionals were considered as withholding key information in case of damaging relations with the families concerned (Ruch & Murray, 2011). 'Good' professionals (health visitors/teachers) were able to preserve their status whilst social workers, perceived as taking tasks involving difficult family interactions and decisions, were construed as the 'bad' professionals (Ruch & Murray, 2011).

Rose (2009) conducted semi-structured interviews and focus groups with professionals in Children's Service teams to formulate the relevant dilemmas. *Collective preferences* were significant in how professionals work towards mutual work goals¹⁴, but themes of 'identity, expertise, territory' and 'power' were significant in confounding the collective decision 'end product' (Rose, 2009, pp. 10-11). Expertise (professionals' knowledge base used towards the team's joint goals) and territory (professional role boundaries) related to differences and unique contributions, but also to concerns for work overlap and how to share expertise (Rose, 2009). Power issues arose from perceived imbalances in decision influence. The key elements found to

affect decisions were the domain of work, professional's status and knowledge and individual personality and persuasiveness (Rose, 2009). Professionals saw advantages in maintaining their own specialisation and expressed concern that reconceptualising in MDTs might detract from this (Rose, 2009).

When professionals define their distinctiveness rather than the means which has brought a team together, individual members will need to find a collaborative way of working in order for an MDT to achieve its objectives (Frost, 2005). Structures that organise a team together in a group support the position of some members over others. Rather than seeing a single team, members may therefore conceive of themselves as a collection of different professional identities and be prone to work duplication (Dorahy and Hamilton, 2009; Weller, 2012). Overlapping functions is significant to professionals' perceived sense of 'usefulness' toward the work purpose and specific contributions are a function of particular roles taken in a team (Reed & Bazalgette, 2006). Role understanding and effective communication are core competencies for effective health care collaborative practice (Suter et al., 2009). Uncertain role boundaries and where overlapping begins/ends, pose difficulties for integrated work teams (Hudson, 2002; Rose, 2009). Unclear definitions may produce 'role violation', when a group can collectively sustain irrational role systems in an unclear context (Hirschhorn, 1988, p. 43).

In the quest to operationalise integrated working, emotional conflicts arising between personal convictions and the integrated working 'ideal' have been poorly understood (Anning et al., 2006; Hudson, 2002). In a children's (ASD) assessment context, an 'ideal' MDT may find itself present a false consensus of the team's decisions for the child, when the assessment is complex and opinions differ (Bartolo, 2001). Particular disciplines frame difficulties differently and framing and role position might conflict with other members' disciplinary work frames, role and/or role perceptions, causing conflict and hindering decision-making. Contested decisions

create further anxieties around the group task (Moxnes, 1998; Stokes, 1994). A review of the possible consequences of team members allotted or adopted roles are therefore pertinent.

5.1.2. Role as Work Behaviour

The traditional understanding of roles in the workplace is according to established job descriptions or organisational hierarchies and although the behaviour associated may be encoded through such formal means, more often it evolves through the actions and expectations of contact with others, from the role demands (Hirschhorn, 1988). A role can form in response to the priorities and activities of unforeseen events (Reed, 2001). Informal roles tend to arise from formal ones and may either support or undermine effective group functioning (Hare, 1994).

In a study of 'roles' as 'behaviours' adopted by group members, Benne and Sheats (2007) reported 47 member role types conforming to three categories: members who accomplished the group task (initiators/information seekers); those who built and maintained the group (encouragers, harmonisers); and egocentric members, who satisfied personal needs (blockers, aggressors). These roles were considered dysfunctional and to frustrate group purpose (Benne & Sheats, 2007).

Where this typology is described limited to illustrating sociological, rational views of small group interaction, an alternative presents role-taking and differentiation that attends to the latent structures of a group, arising from psychoanalytic group process theories linked to fantasy/fairy tale archetypes (Moxnes, 1998, 1999). It aligns with Bion's (1961) basic assumption positions, using core family roles and Klein's (1987) concept of splitting. Where basic assumptions are psychological positions in the organisation, serving the need for emotional retreat, deep roles are fantasy-based, social constructions of the repeated patterns of behaviour held in the mind of a group, which 'attach to some central figures [and] contain the group's collective projections'

(Moxnes, 1999, p. 109). Such roles are characterised by emotions, rather than reflection or fact, being 'full of clichés, empty phrases, stereotypes and over-generalisations' (Moxnes, 1998, p. 291). The archetypal figures relate to Bion's (1961) basic assumption positions: the King and Queen are linked to BaD; splitting to good and evil, as BaF; and Prince and Princess to the BaP. These role definitions materialise in organisational psychology management-training: Prince finds Princess (BaP), Hero finds Villain (BaF), and the organisation finds an Almighty (BaD) (Moxnes, 1998).

Table 13 illustrates the proposed deep roles matrix (Moxnes, 1998):

		SPLITTING	
		GOOD	BAD
THE FAMILY	FATHER	GOD/KING	DEVIL
	MOTHER	QUEEN	WITCH
	SON	CROWN PRINCE	BLACK SHEEP
	DAUGHTER	PRINCESS	WHORE
THE HELPERS	SPIRITUAL	WISE MAN	FALSE PROPHET
	MATERIAL	SLAVE	DISLOYAL SERVANT
	TRANSFORMATIONAL	HERO/WINNER	CLOWN/LOSER

TABLE 13
DEEP-ROLE MATRIX OF SEVEN ARCHETYPAL ROLE FANTASIES FOUND TO DOMINATE GROUPS AND ORGANISATIONS, EACH DIVIDED INTO POSITIVE/NEGATIVE MODALITY FROM MOXNES (1998)

Whilst 'speculative' and 'a heuristic quest for a theory of how people experience each other in groups', sharing deep-role fantasies may promote group cohesion and internal integration; the less members acknowledge, discuss and analyse the established deep-roles, the more difficult it is to extricate themselves from their adopted positions (Moxnes, 1999, p. 99).

In such a framework however, members are seen individually as ‘unidimensional stereotypes’ rather than as complex beings capable of role combinations (Hare, 1999, p. 116).

An alternate way of appraising small group interaction uses a dramaturgical focus (Moreno, 1978), whereby characteristics of the situation (context), those involved directly (actors) or indirectly (audience/persons absent), feature (Hare, 2003). Attending to the meaning of interaction in functional terms considers individuals in role, the specific task and the types of exchanges being made (Hare, 2003).

According to the dramatic perspective, roles are the internal image an individual wishes to convey; in essence, the contrived sense of self wanted to be projected to the world (Kivisto & Pittman, 2013). This sees individuals needing to enact the characteristics necessary for the reality they wish portrayed in a two-way perception, whereby the adopted role is also one anticipated (Kivisto & Pittman, 2013). The professional who cannot successfully employ common understanding risks being cast a failure; for example, the friendly flight attendant who seems surly or the wealthy insurance agent who dresses shabbily are conflicts of known expectations (Kivisto & Pittman, 2013). Although a professional might understand their version of their role, it needs to be conveyed as intended, for which ‘scripts’ are important devices. These constitute ‘a taken-for-granted quality’ whereby, rather than generating new forms of talk, ‘a stock of well-worn scripts’ are used (Kivisto & Pittman, 2013, p. 277).

Well-used phraseology, as a valuable tool, places emphasis on professional narratives. Everyday conversations, and formal management communications, construct the shared meanings that consists in collective sense-making, whereby the interactively created social reality becomes then, organisational reality (Boyce, 1995). The collective sense-making and overt phraseology of a basketball team over a season, achieved dynamically, was ‘tough, smart and unselfish’, with players negotiating consciously to use these terms productively and centre themselves both

individually and as a team (Boyce, 1995, p. 111). Conversely, in an organisational context, the described reality was a 'structurally closed system', revolving around an established collective 'truth' with common meanings confirmed and extended internally in logical ways (Boyce, 1995, p.130, 133). This shared and predetermined meaning remained unmodified from members' experience. Members aligned themselves with the collective sense and maintained it intra-organisationally, protecting it consciously and unconsciously through mutual effort. New facts potentially updating of current beliefs were unpursued and experiences unsupportive of the shared point of view were not discussed. Anything that contradicted the established collective sense was 'filtered out' (Boyce, 1995, p. 132).

Theories that favour communal meaning and individuals as collectives, have been preferred over static theories of individual roles. Position theory accounts for how everyday conversations generate the understanding of beliefs, values and responsibilities, hence allowing greater variability in individual role positions (Matthews & Singh, 2015). Where social dialogue creates reality, inflexibility to change can be thought of as a factor of language limitations, which can be addressed by introducing new language and meaning (Matthews & Singh, 2015). This may be preferable to a dramatic model, with prescribed scripts (Kivisto & Pittman, 2013) and might open organisational systems, helping consolidate ideas (Boyce, 1995).

Organisational Role Analysis (ORA) encourages professionals to examine and articulate management and leadership positions, allowing roles to be more effectively adopted (Reed & Bazalgette, 2006). According to ORA, one's role in an organisation becomes 'an idea in the mind' with constructed behaviour patterns enabling enactment of the perceived role (Reed, 2001, p. 3). Role is a 'mental regulating principle' by which to manage particular behaviour responses, based on a person's known, lived experience for complex interactions of feelings, ideas and motivations, and aroused by engagement with an organisational aim (Reed & Bazalgette, 2006, p. 3).

The formation of three constructs — person, role and system — are illustrated in Figure 11:

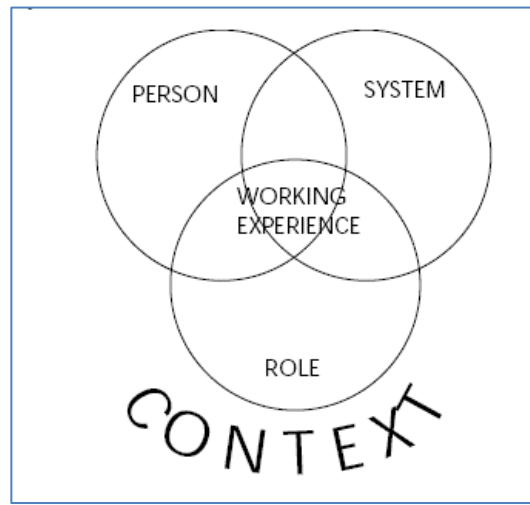


FIGURE 11
VENN DIAGRAM ILLUSTRATING MUTUAL RELATIONSHIP OF
PERSON, ROLE AND SYSTEM
FROM HUTTON (1997)

This illustrates experiences in a context in which work is conducted, as feelings, thoughts, desires and reactions of the *Person* engaged in the *System* through their adopted *role*, with the implication that work for the benefit of the system requires the functions of the person in role (Hutton, 1997).

Differences in roles are also psychological (how one behaves) and sociological (how one ought to behave, according to the mind set of others in the organisation): sociology influences roles overtly and covertly, but cannot define them because these are only realised by the person in role (Reed, 2001). ORA was applied by a lead hospital chaplain to consider roles and boundaries of practice in the Chaplain's department, in order to avoid overreaching management expectations of the Hospital Board. It also assisted directors of the same organisation in managing negative feelings related to inter-departmental system boundaries (Reed & Bazalgette, 2006).

When roles define individual work behaviour, combined with reliance on other individuals in their roles, location in the context of the work system is relevant.

5.1.3. Organisation as System

System refers to an organic, bounded series of activities distinguishable from the environment (Reed & Bazalgette, 2006). It delineates relationships between the parts and the whole of an organisation, creating boundaries between activities and the people who conduct them (Zagier Roberts, 1994a). An open system is one in continual interaction with the environment, contingent on a defined purpose that plans technology, resource and processes within its boundaries (Reed, 1999).

Akkerman and Bakker (2011) reviewed the literature¹⁵ on maintaining and crossing organisational boundaries. Studies focused on how professionals with different expertise, tasks or backgrounds collaborate, when high specialisation requirements lead to inter-disciplinary work patterns, such as in health, science and academia. Boundaries, defined as ‘socio-cultural differences’ interrupted interaction and action, with interdisciplinary professionals termed ‘boundary crossers’ or ‘brokers’ (Akkerman & Bakker, 2011, p. 139). These individuals not only bridge worlds but represent the divisions of related worlds – they are thus in the valuable position of being able to introduce new practice, but are also on the periphery and may never fully belong to or be acknowledged as a participant in any one practice (Akkerman & Bakker, 2011).

Boundaries can be ambiguous. Middle ground belongs to either side, having a sandwich effect for people at the boundary: 'on one hand they enact the boundary by addressing and articulating meanings and perspectives of various intersecting worlds. At the same time [they] move beyond the boundary in that they have an un-specified quality of their own (neither-nor)' (Akkerman & Bakker, 2011, pp. 141-142).

Organisations as activities bound by a system require clarity of the ‘primary task’ and a clear, shared understanding of what primarily, is intended to be achieved (Zagier Roberts, 1994b). In normal circumstances, this official purpose is evident (what ought to be done). The existential

task relates to the beliefs individuals have of their roles and activities (what they *believe* they are doing) and the phenomenal task (what they *are* doing) may be inferred from observing work behaviour (Armstrong & Rustin, 2015; Zagier Roberts, 1994a). This can explain how influential processes or decision-making may become endemic to an organisation, reflecting prevailing beliefs about the primary purpose of the organisation and revealing potentially confounding ‘anti-task’ behaviours (Zagier Roberts, 1994b).

Understanding the organisational aim illuminates how individuals might present their role in a system structured to achieve this aim, is influenced by their belief and ownership of that aim and supports their conduct (action and behaviour) to best accomplish the aim (Reed, 2001; Reed & Bazalgette, 2006). Armstrong and Rustin (2015) indicate that the primary task, as constructed by organisational members is not a given and is often disputed, particularly when internal diversity means more than one set of beliefs and values collide.

Differences in work perspectives and notions of boundaries of practice has been interpreted according to position theory (Matthews & Singh, 2015). Professionals may adopt a position through discourse, which explains their stance when decisions cause conflict. Position theory conceptualises conflicting organisational dilemmas along a continuum; individuals can explore where they might position themselves and their subsequent associated choice of practice (Matthews & Singh, 2015).

ORA also promotes insight into the internal (mental) image of institution-as-system and boundary as concept-in-mind, formed by the management of linked activities (networks) within boundaries (Reed & Bazalgette, 2006). The secondary head teacher of pupils from disadvantaged homes, for example, uncovered a constructed organisation-in-the-mind that ‘split’ the school into a ‘good’ lower and ‘bad’ upper school according to the behaviour of pupils responding to different compensatory models in each (Hutton, 1997).

Reed (1999) argues that management *is* the boundary. Boundary-crossing leadership, found to promote organisational success, is ‘the ability to manage and integrate multiple, divergent discourses and practices across social boundaries’ (Akkerman & Bakker, 2011, p. 140). Conversely, leaders may assume status through unconscious idealised ‘positioning’ by team members and expect, perhaps even demand idealisation and avoid responsibility (Kapur, 2009).

Such processes are reminiscent of ego defences such as projective identification, whereby individuals unconsciously relocate feelings or attributes of the ‘self’, and ‘introjection’, whereby individuals take attributes from others and install them in their inner world (Hutton, 1997). Despite the desire to support and promote employee development, managing envious attacks and negative feelings from projective identifications may lead to the acting out of ‘harsh super-ego’ roles during disciplinary processes, or withdrawing from the ‘shattered morale’ out of over generosity to employees (Kapur, 2009, p. 42). In addition to recommending a need to explore unconscious motives for taking leadership positions, examining personal management styles might illuminate negative projective processes (Kapur, 2009).

5.1.4. Anxiety Effects

In psychoanalytic thinking, cultures, structures and work routines may be overt defence mechanisms (Brown & Starkey, 2000), with covert, unconscious defences such as splitting and projection, employed to avoid difficult, anxiety-provoking feelings (Armstrong, 2010b).

A range of routines might be employed as social defences against difficult, anxiety-provoking work, including splitting up relationships, taking on allotted roles in a projective system, depersonalisation, detachment and denial of feelings, collusive distributions of responsibility, irresponsibility and delegation, with ritual task performances (Armstrong, 2010b; Armstrong & Rustin, 2015; Lawlor, 2009; Menzies, 1960).

The concept of basic assumption reactions account for the ways in which individuals collectively resist the real or imagined threat a group context poses to their individuality (Armstrong, 1997; Bion, 1961). Emotional experiences, from consultative accounts, may explain the inter-relatedness of individuals in a group or organisation. Individuals may carry the culture of their organisational group context as a state of mind in the conduct of their work activities (Armstrong, 2004). Roles and basic assumptions are both characteristic of defensive anxiety reactions, asserting that an organisation's primary task is survival (Armstrong, 2004; Moxnes, 1999). Individuals in all organisations adopt roles and these are felt to be more prevalent when a group is pressured, has functional problems, and/or has a complex task to fulfil (Moxnes, 1999).

Hirschhorn refers to organisational rituals as externalised, visible forms of irrational defence practice and 'anxiety chain' effects, as interconnected processes between individuals, whereby the anxieties experienced in work might lead to 'stepping out' of work roles as a form of avoidance (1988, pp. 42, 47). There are two possibilities associated with particular work activities. To take on the role as it is intended, or 'escape the risks' it presents thereby maintaining the anxiety-chain (Hirschhorn, 1988, p. 55). Mirroring effects of anxieties transmitted across different levels of an organisation are powerful psychosocial phenomena (Armstrong & Rustin, 2015; Maitlis & Ozcelik, 2004). Affective tone may be influenced by group-level processes and correlate with employee absence behaviour (Mason & Griffin, 2003). Group members who no longer share a collective sense of an organisation leave: the ultimate expression of disagreement with an organisation (Boyce, 1995). Basic assumption mentality may be implicated in recruitment and retention of staff and long-term absenteeism, and emotional management of the presence and commitment of group contributors to the work task, as 'retainment', allows for optimal group function (Morgan-Jones, 2007, p. 23).

5.1.5. Productive Work

In contrast to anxiety-provoked role disruption (Hirschhorn, 1988; Moxnes, 1999) and basic assumption positions (Bion, 1961), work group mode describes the quality of a group at work, with thinking and talking based on the context (Granville, 2010). Constructive exchanges tolerate decisions that potentially provoke anxiety, recognise boundary limitations and authority, remain aware of time and are flexible to consider and accept change (Bion, 1961; Granville, 2010).

Grounding oneself in reality, keeping the primary task in mind and confronting the work represented in a role, rather than avoiding its risks are necessary to contain ‘anxiety chaining’ and limit risks for overstepping boundaries (Hirschhorn, 1988).

Bion’s (1961) work group or basic-assumption group do not exist per se, but are interrelated modes of mental function in the same way as conscious and unconscious processes (Armstrong, 2010a). Basic assumption behaviours are thus more transient and less durable, as well as less visible in the group (Hirschhorn, 1988). Describing them provides a ‘comforting illusion of simplicity’, but the shifts between them reflect ‘in-the-moment’ domination of one over the other that does not follow a sequence (French & Simpson, p. 1864). Group work involves a dynamic flux of the primary task boundary focus, of desires to complete the task and contain the created anxiety (Hirschhorn, 1988).

Using psychoanalytic concepts, psychological demarcations protect individuals from risk and uncertainty and assist in effective task completion, thus requiring one to delineate the boundaries of role, departments, specialism or actions (Hirschhorn, 1988). This necessitates rule-based, organisational or inter-departmental and role specific separations (boundaries) to be clearly established.

5.1.6. Summary

The secondary literature review emphasises that members in a group may adopt individual positions, as roles, which potentially reflect the attitudes and positions of other members. This pervasiveness may also be an aspect of the work context, in the organisation as a system. A systems view considers the context in which boundaries around role activities are established and psychoanalytic consultancy experiences reveal an unclear role context with emotional uncertainty, possibly leading to effects appearing as conscious or unconscious defences against anxiety from, and because of, the group context of the work.

Enabling work task effectiveness by minimising emotionally laden confounds requires clarity of organisational aim, boundaries, role and specialism which protect against risk and uncertainty.

In the following section, the findings of the current study are discussed in the context of this review.

5.2. THEORETICAL DISCUSSION

CGT findings are presented here, and located in the context of the literature. Key findings include the core position of the decision-making processes of professionals, used in the context of the referral system and child assessment ‘pathway’, and the outcomes relevant to individual child cases. Possible collaborative frameworks for the MDT at the Centre are discussed in terms of the reviewed literature and psychoanalytic concepts pertinent to a group, role taking, systems effects and task/role boundaries.

5.2.1. Summary of the Theoretical Position

The purpose of this CGT was to explore the processes that members of a mixed MDT use in making assessment decisions for child cases and how this might influence the outcome. Do such processes undermine or strengthen joint working? Did useful theory emerge to illuminate how different professional disciplinary perspectives joint work may be effective?

Based on the CGT analysis of *active processes* and particular *talk patterns* from actual discussion transcripts, two broad theoretical categories explained professionals' decision-making in the operation of a referral system and in the use of avoidance functions.

Decision-making processes explained how system functions were maintained and task difficulty avoided.

According to expectations to maintain the system and the inter-dependent pressures found involved, *expediency* was central to effective function. Decision-making involved weighing-up and sifting-sorting-filtering significant child detail. The use of *centralisation* and *convenience*, with a *continuation of functions* further supported the apparent need for expediency.

Expedient decision-making in the system was interrelated. Core theoretical categories used by professionals in conduct of system routines for these child cases are illustrated in Figure 12:

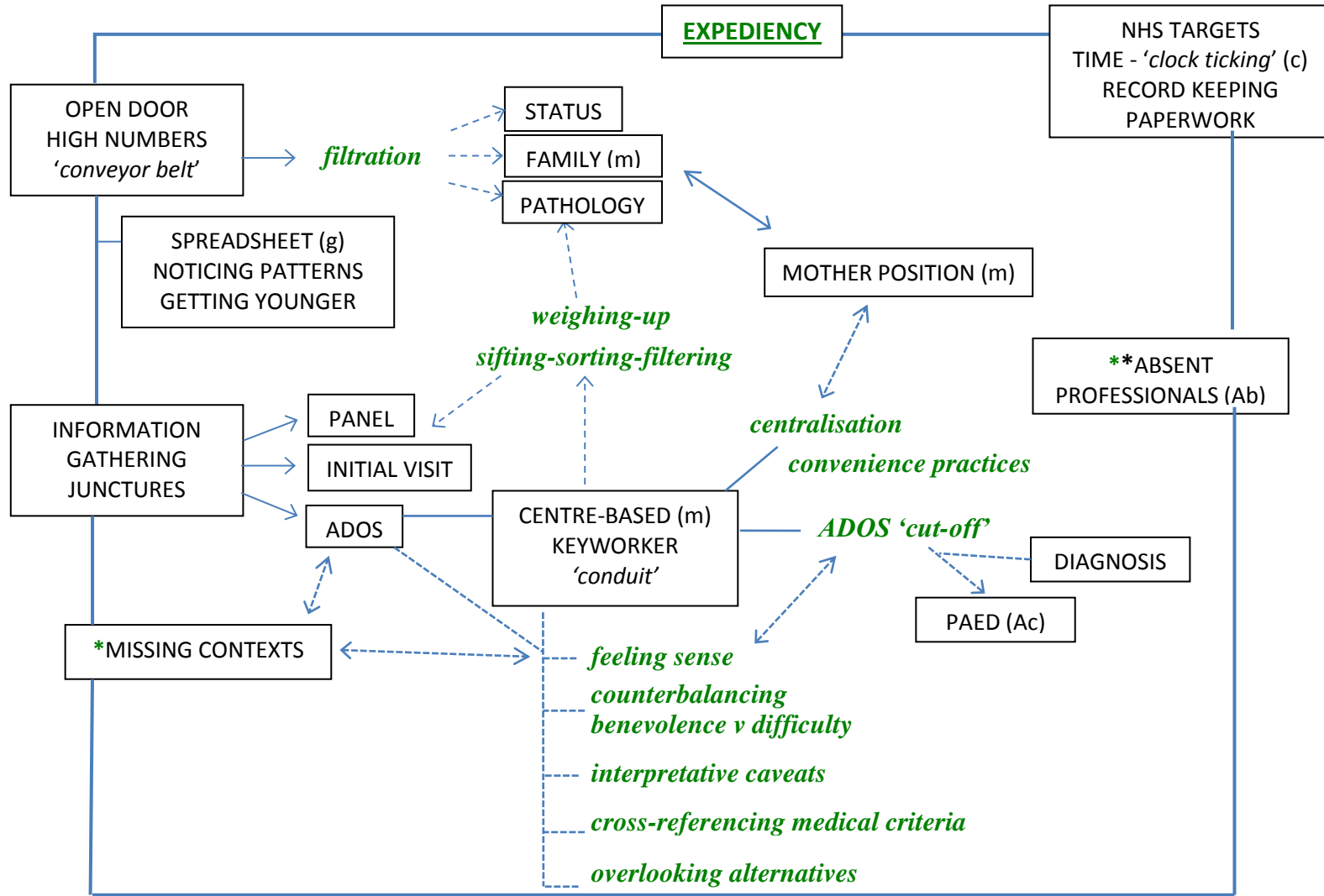


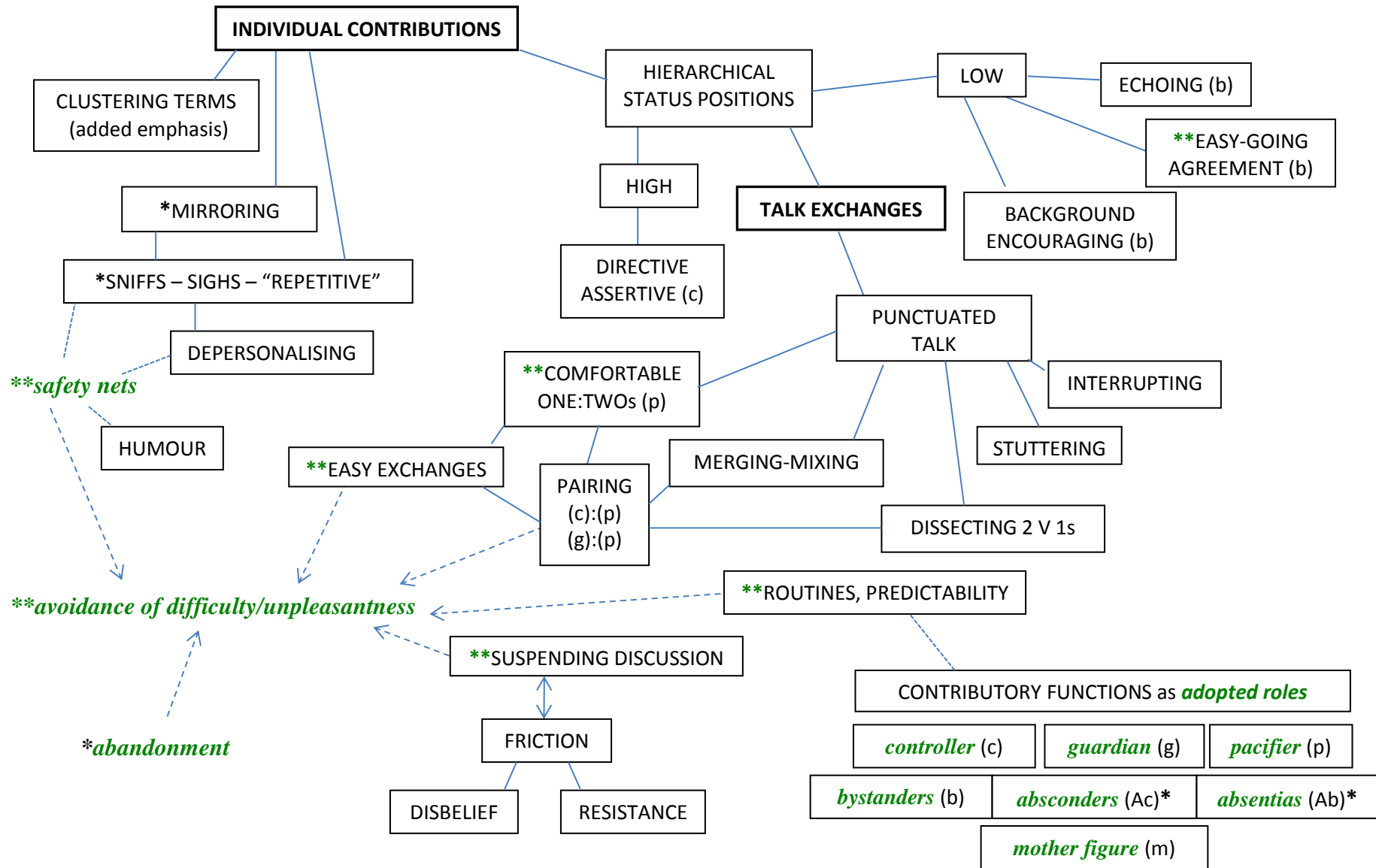
FIGURE 12
DECISION-MAKING UNCOVERED WITHIN THE REFERRAL SYSTEM

KEY *Green fonts* = Core theoretical categories. Black fonts = Theoretical category codes.
 (Ab) = links to 'absentias'. (g) = links to 'guardian'. (c) = links to 'controller'. (p) = links to 'pacifier'. (m) = links to 'mother-figure'. \longrightarrow = apparent system routine links.
 (b) = links to 'bystanders'. (Ac) = links to 'absconders'. * = showing *continuation functions*. * = showing *abandonment*. \dashrightarrow = uncovered decision-making process links.

Professionals' talk exchanges emerged from coded *language patterns* and reveal the theoretical position for decision-making potentially affected by *avoidance of difficulty* and *unpleasantness*. This included the sense of abandonment with a difficult task; conduct towards the emotional content of the work, including responses to the position of the child's mother; a preference for predictable routines; and a finding for professionals' particular contributory system roles.

Figure 13 illustrates decision-making as an avoidance of difficulty, with core categories that were developed from the coding of language patterns.

The interrelationship of core category active processes and interactive language patterns is evident in Figures 12 and 13. Elements not directly evident and referenced in the Key for each, demonstrate that absent professionals and missing contextual information influenced the continuation functions of professionals and the roles they adopted (in parentheses) in system conduct (Figure 12) and in avoidance functions (Figure 13).



KEY *Green fonts* = Core theoretical categories. **Black fonts** = Theoretical category codes
 (Ab) = links to 'absentias'. (g) = links to 'guardian'. (c) = links to 'controller'. (p) = links to 'pacifier'.
 (b) = links to 'bystanders'. (Ac) = links to 'absconders'. ** = showing *avoidance of difficulty/unpleasantness*. * = showing *abandonment*
 → = apparent system routine links. - - - -> = uncovered decision-making process links.

FIGURE 13
 DECISION-MAKING UNCOVERED AS AVOIDANCE
 FUNCTIONS

The complex, interdependent nature of these processes revealed the fragmentary function of this MDT. Decisions in these cases were limited by the context: professionals tended to avoid the difficult nature of the task and showed a preference for predictability and routine, with evidence for a reliance on using the ADOS ‘cut-off’ score. ADOS was used to establish ASD diagnosis.

Analyses therefore begin to suggest that, in this particular domain of child neurodevelopment assessment, joint working is potentially too difficult. A medical model was used to explain the child’s difficulties. Core theoretical categories in decision-making indicate that singular use of this approach may undermine MDT collaboration. Increasing the scope for the contributions of alternate professional disciplines might strengthen decision-making. A more diverse approach might widen appreciation for a child’s particular situation (strengths, as well as difficulties) and support a variety in professional teams.

The following sections describe more fully the Centre context, in which systems affected decision-making processes occurred.

5.2.2. Decision-making: Context and Processes

5.2.2.1. Context

The context for professional decision-making in this study was the referral system of the Centre, in which a child assessment ‘pathway’ operated.

A core Centre team, SLT, EP, M, SpHV, FamCo, EYPrac, carried out immediate system processes. SLT, EP and M were central to the conduct of panel meetings and were instrumental in making decisions. FamCo, EYPrac and M conducted the Initial Visit, according to location. SpHV and EP engaged in the Keyworker assessor role and with SLT, occupied specialist (interpreted in analyses as ‘status’) positions in the Centre. SISS specialist teachers provided

variable support to the context routines. Other professionals involved in the system, evident in case analyses were a paediatrician, a speech and language therapy trainee and a teacher assistant.

Where the study aimed to improve understanding how mixed (EHC) professional disciplines might work together, and the effects then as outcome for the child, this team's explanatory approach was a medical model of disability. From the dialogues, the referral system appeared open-door: parents and professionals could refer children about whom they had concerns. The Centre's system and 'pathway' provision was therefore perceived as a locality diagnostic service. The processes evident in this system context are explained next, with each theoretical concept evident from the system routines and perceived avoidances.

5.2.2.1.1. System Processes

Expectations of system maintenance and inter-dependent pressurising effects revealed potential stressors for professionals. The open-door arrangement showed a cycle of increasing numbers, and much younger referrals. These high numbers limited the time available to discuss each and created efforts to retain a sense of the individual child admitted into the system. Professionals prioritised system record-keeping, relevant for target setting, time management (the NHS 'clock-ticking') and evidence of decisions taken in respect of the child using NICE (2011) guidelines.

Absence and distance of professionals revealed Centre professionals felt abandoned in the difficult diagnostic task. Task difficulty, seen partly in system maintenance, was also felt in a pressure to respond to the parent (mother) and the perceived sense of professionals taking responsibility for alleviating concerns about the child.

Professionals used expediency, including weighing-up, centralisation and convenience and continuation of practice to make decisions. They adopted avoidance functions over task difficulty. Clarification of each of these follows.

5.2.2.1.1.1. Weighing-up

In the time available, weighing up the significance of the referral information and salient judgements pertaining to the individual child could support attending to high numbers.

Professionals already known to the Centre team, or those in elevated community positions (Head of a Special School/University researchers), were accorded more 'weight' than, for example a GP or other unknown professional. The extent of concern shown by the mother, and the family's background including whether siblings or close relatives had ASD, was considered important, as well as descriptors of child pathology.

When professionals reviewed child responses during ADOS assessment, conflicting versions of the child emerged from using a 'feeling' sense and interpretative caveats of the child's performance, cross-referenced with medical criteria. Professionals counterbalanced positive responses with more concerning abilities of the child and tended to overlook the child's perspective or view, 'now I did say that he gave me some nice eye contact ... but we don't- we only get a choice here with this'.

5.2.2.1.1.2. Convenience and Centralisation

The system appeared maintained because professionals used short cuts. Specialist roles kept their position at the Centre, and compensated for limited time away by 'drawing in' others' information about the child. This saw the Keyworker specialist acting as a 'conduit' for other professionals' information and Early Years professionals preferred to conduct the home visit, at which time questionnaires were left with parents for completion ahead of a Centre visit: parents were required to bring children to the Centre for an ADOS assessment, arguably a socially isolating experience for the young child.

5.2.2.1.1.3. Continuation of Function

Data capture in the ‘real world’ highlights the management of natural (unforeseen) events and where ‘absences’ occurred, either of particular professionals, or contextual limitations professionals adopted to continue system functions. This followed still when there appeared to be limits on significant child developmental or experiential information or there were particular specialist professional views unavailable, which may potentially have supplemented child assessment detail.

The finding for decision-making as avoidance from perceived, unpleasant aspects of the work task, is explained next.

5.2.2.1.2. Avoidance Functions

5.2.2.1.2.1. Difficulty and Unpleasantness

Professionals demonstrated avoidance of the difficult nature of the task. Humour, talk exchanges, predictable routines and adopting role-specific functions in their maintenance of system and ‘pathway’ practices were characteristic defences.

In their talk exchanges, professionals avoided conflict through easy, comfortable agreement, particularly in the form of ‘echoing’. Individual contributions to discussion were unchallenging, easy-going, status linked agreements. Where a few frictional discussions occurred, these remained suspended with professionals expressing disbelief or a non-negotiable stance.

Dyad and, particularly, group talk interactions assumed characteristic patterns. ‘Punctuated’ talk, regarded as interrupting/stuttering, dissecting or merging-mixing, ‘two versus one’ or paired

exchanges ('comfortable one:twos') were found as particular features in the talk exchanges of professionals. In addition, professionals 'mirrored' experiences of case work, embedded in their talk as sniffing, sighing, using particular phraseology and potentially reflecting attributes of the child's described behaviours, 'speech≈ dela:y(...) and communication delay and no eye contact no pointing no smiling(1)'.

Adopted roles observed in the professionals' routine work positions reflected the interactions by the core Centre team, whose regular work contact appeared central to the referral system (see Panel attendances, pages 88-89), and other members positioned on the fringe of their activities. These roles (controller, guardian, pacifier, bystanders-absconders-absentias and mother-figure) were previously defined as researcher constructions (pp. 117-122).

There was friction between the Manager/'controller' (SLT) and the Under 6 Team Lead/'guardian' (EP). Whilst SLT, as Centre manager, 'controlled' overall processes, EP could retain a distinctive position, alongside, as Team Lead. The Manager of SISS/'pacifier' (M) acted to ease relations and the cited pairings, evident in the talk exchanges were more between M and SLT, felt often at the expense of EP.

Role functions also appeared to rest on status differences maintained by professionals. Fringe members contributed as observers ('bystanders') of more overt actions; their influence consisted of passive agreeing or particular background encouragement, to decisions made by core team members.

System influences also included absent figures ('absentias'), for whom staying away from discussions, potentially as a form of task avoidance, was possible by the core team who continued functions despite limitations. This seemed to reinforce the sense of professionals left with a difficult task. Likewise, the perspective of the paediatrician ('absconders') presented as perhaps avoiding to lead with particular decisions, instead applying their authority to confirm the

child's diagnosis according to the Keyworker. With case unfamiliarity from no previous involvement, this involved determining an opinion using alternate, indirect sources from other professionals, 'and the (...University) people ha-[were](.) concerned'.

The observed outcomes for these children, apparent after system decision-making processes, follow next.

5.2.3. Child Outcomes

The Centre provided a locality diagnostic service, in which professionals ascertained whether the difficulties experienced by these particular children were consistent with ASD. The assessment 'pathway', gathering child descriptors at information-gathering junctures (see Figure 10), was the means to establish whether ASD was relevant in each case. Each child received a diagnosis as the culmination of assessment processes. The ADOS 'cut-off' score was significant in determining whether ASD was appropriate, whilst partial decision-making processes using ADOS favoured the construction of such a 'cut-off' point.

From theoretical description, an understanding of the Centre MDT is discussed in the following section, using pertinent aspects from the secondary literature. Appreciation of the observed joint work position is then elaborated from the standpoint of reviewed psychoanalytic concepts.

5.2.4 MDT Work

In the literature, MDT configuration is important in supporting how professionals maintain the stance (Anning, et al., 2006; Frost, 2005; Leadbetter, 2006). The MATCh CDT (Anning et al.,

2006) was similar to the Centre MDT. Both focused on medical diagnosis and maintained a structure whereby professionals could maintain distinctive roles and their own management and accountability processes (see Centre structural diagram, page 29, and section 2.1.2.1, page 35). During the period of research, social care¹⁶ ‘withdrew’ from MDT contribution and was absent from these child assessments. In sum, describing team configuration does not necessarily translate into practice. This notion of variance in mixed MDT structure is discussed next.

5.2.4.1. Mixed MDT Configuration

In the current study, although there was MDT professional availability, the expectation to contribute to teamwork varied and was subject to organisational and/or professional preference.

Bartolo (2001) highlighted professional assessment of apparently similar child presentations differing according to particular, medical or educational disciplinary focus. The awareness of professionals about inter-disciplinary components of child assessment might affect the nature of support then offered to children and families (Bartolo, 2001). The current study sought to extend such research by examining how different EHC disciplinary perspectives might work jointly. When specialism variety was available (as in the Panel), priority was given to system functions rather than specialist discussions regarding the child. This is an important finding for effective facilitation of the three (EHC) disciplines working together.

The dilemma Children’s Services teams have reconciling concerns for work overlap and threats to professional identity when specialisms are integrated by MDT models, could influence the Centre’s practice approach (Anning et al., 2006; Leadbetter, 2006; Rose, 2009). Where the context of teamwork is a previously established CDC clinical model, this perspective prevailed. In anticipating different EHC disciplines working together might bring together assessments consisting of discussions about a child’s strengths and difficulties, arising out of the evidence of

their lived experiences (Bartolo, 2001; NICE, 2011), this mixed MDT was fragmented. Professionals integral to the assessment were absent from discussions. Analysis revealed that these absences were also limitations (missing contexts) concerning child developmental or experiential information. This study argues that missing information might have been provided by 'absent' professionals.

Whilst this MDT might notionally reflect partnership working Level 3, Co-ordination (see Centre information page 26, and page 34; Frost, 2005), findings suggest the team joint worked at mixed levels. Multiagency as more than one agency working with a client, but not necessarily jointly and work prompted either by joint planning, or simply replication (overlap) through a lack of clear co-ordination (Warmington, 2004), seems relevant to the operation of this MDT.

The research took place over a long period, during which time the Centre evolved its practice, including team changes¹⁷ and adopting the recent NICE (2011) guidelines. At the study outset, the aim of the Centre was to support children experiencing neurodevelopmental difficulties, and their families. Toward the end, the Centre defined its practice differently, emphasising an ASD diagnostic service.

Reports of unsuccessful practice and missing MDT communications in critical social care reviews (DCSF, 2009; Laming, 2003) potentially featured here as absent professional voices. CHR04 presented concerns about assessing child difficulty without the 'voice' of the social work profession. Although Centre description of practice is for the three EHC perspectives, findings indicate the absence of an alternate view of the child, other than that of a medical, 'within child' discourse. TCHR_1 provided information of CHR06's response in nursery. However, this description did not feature for the other children. Thus CHR05's ADOS assessment continued although visits had not occurred: 'I haven't been into (name) yet I will do'. Findings reflected Bartolo (2001), for a dominant explanatory model of practice in professionals' decision-making

for children with the type of difficulties experienced in this study. The health model in the Children Trust pathfinders is less integrated with other services than the case for education and social care provisions (Bachmann et al., 2009).

Decisions developed without consideration of alternatives are inherently risky (Galanter & Patel, 2005). The ‘clinical benefits’ of ASD specific assessment tools are uncertain; whilst useful as a systematic framework to assist the diagnostic process, the possible harms of ‘false diagnoses and false reassurances’ are emphasised (NICE, 2011, p. 108). Diagnosis for CHR04 might arguably have been made through ‘confirmation bias’ (Galanter & Patel, 2005; Nickerson, 1998): the Keyworker indicated the need for a diagnosis to the paediatrician, by signifying other professional opinions and the ADOS ‘cut-off’ score whilst information suggested a consideration of possible alternatives: ‘hhh and she didn’t mention(2) absences to you did she?’.

Decision-making might be linked to the expediency requirements of operating a system under pressure, also an issue in guidance (Boddy, et al., 2006; NICE, 2011)⁶. From these individual assessments at this Centre and with the reported prevalence of high numbers of ASD diagnoses (Waite & Woods, 2007), concerns surrounding their source (Selfe, 2002) and in respect of a ‘post-code lottery’ (NICE, 2011, p.196), such findings might be considered potential reasons for variability.

Joint working may enhance uniformity of practice decisions (Boddy et al., 2006) with evidence promoted ways to work, shown (Anning, et al., 2006; Leadbetter, 2008). The findings presented here however, support previous research that simply putting professionals together does not guarantee better practice (Hughes, 2006; Sloper, 2004).

Findings for status differences in professionals’ talk exchanges indicate that variety and unique contributions have potentially become anxiety-provoking concerns about work overlap and how to share expertise and territory (Hudson, 2002; Rose, 2009). Decision-making might arise from

the team situation. It may be argued that the professional absences observed here were unconscious contributions to the difficulty inherent in confronting task requirements, leading to withdrawal from the field (Moxnes, 1999; Ruch & Murray, 2011). These were potentially reinforced by perceived lower status professionals being available to act instead, at the task boundary (Hirschhorn, 1988).

From this perspective, practice variability is a product of the human condition responding to the nature of the task and working in a group (Armstrong, 2010a; Bion, 1961).

In the next sections, psychoanalytic explanations for the findings are considered. The Centre's primary work task, possible impacts from working as a group, and reasoning for perceived avoidances and role-taking functions are explored.

5.2.5. Primary Task

In reference to the literature, a question posed by the study might be to what extent this professional team were aware of their primary task (Zagier Roberts, 1994a). The existential perspective would ask what professionals would say or think it is, whilst the phenomenological view considers that professionals were unaware of the potential affective components of their decision-making.

If a primary task is defined broadly, such that professionals want or need to consider everyone referred to their services, this vagueness may lead to insider-imposed, alternate definitions acted out in the system (Hirschhorn, 1988).

Professionals in this context lacked awareness of a clear task purpose. The system, previously described, is 'open door'. The Centre leaflet (see page 26) claims service users might receive a 'comprehensive specialist assessment service based on agreed areas of need'. Comprehensive implies broad; agreed areas imply anything that is highlighted or can be discussed. Broad and

general definition terms may foster uncertainty of task purpose in a group, leading to fragmentation and/or members establishing their own versions of a primary task (Zagier Roberts, 1994a).

This MDT was fragmentary, with absent voices and significant professionals avoiding contributing to the task with which the core team engaged. Over the period of the study, changes were apparent in primary focus and professional contribution (see section 1.4.4, pp. 25-28 and reflexive notes, pp. 230-231), including the ASD diagnostic service reframed from a needs-based response to neurodevelopmental difficulty, and panel attendance by the social worker re-prioritised.

‘Role violation’ and uncertain role boundaries (Hirschhorn, 1988, p. 42) in this context constituted anti-task behaviours (Zagier Roberts, 1994a), reflecting sophisticated, basic assumption group activity (Stokes, 1994). The next section discusses potential group influences on Centre practice.

5.2.6. Working as a Group

The minimum size of a ‘group’ is considered three: ‘two members have personal relationships; with three or more there is a change of quality (interpersonal relationship)’ (Bion, 1961, p. 26). This study asked how professionals of diverse disciplinary backgrounds bring their professional understanding regarding the child to a situation where group decisions are required. There are three EHC models for thinking about child need.

A singular model to understand the child, as in this study, has been noted previously, with professionals preferring to maintain distinctiveness together (Bartolo, 2001). In the current study, significant professionals were often absent, keeping distance - fleeing (Bion, 1961) from the scene. Joining diverse approaches is perhaps difficult and thus avoided. How the significant

elements of role understanding and effective communication (Suter et al., 2009) may be used to facilitate particular EHC viewpoints to be jointly heard, requires more consideration. Bion's (1961) perspective might assist in further understanding.

Inclinations to avoid or take flight from anxiety and professional conflict (Ruch & Murray, 2011) were pertinent to the function of this team. Previous reference to the sophisticated basic assumption group's 'fights for supremacy' were revealed in status awareness and hierarchical talk differences (Stokes, 1994). Aligning by particular professionals, particularly SLT and M, and modes of talk exchanges heard by the core triad group (SLT, EP and M) involved two versus one paired exchanges between SLT and M, with EP keeping distance. At other times, talk was dissected, speaking over each other or as merging-mixing, SLT talked aloud of own concerns whilst the pair (EP/M) spoke together on another matter. This may be perceived as a form of basic assumption (BaP) group activity (Bion, 1961). Such a mode of thinking is described as transient, from which perspective professionals fluctuated in their level of work focus (Hirschhorn, 1988), with the EP the individual who most often 'pulled' thinking back to the reality of the task, 'yeah so we done with the(.) spread sheet'.

Time was significant. Professionals lost track of time as they filtered the high numbers through the panel and seemed to lose sense of the length of time the child was 'held' in the 'pathway', 'Wait a minute (1) that's- oh gosh he's been going around a long time hes been through panel (...) [four] times'. This loss of a sense of time and quick, routine decisions from apparently limited discussion was captured in panel and described talk patterns and supported the perception of 'as-if' responses and basic assumption group activity (Bion, 1961; French & Simpson, 2010; Stokes, 1994).

Basic assumptions as unconscious defences against anxieties and unpleasantness (Bion, 1961) and the viewed, social constructions of repeated behaviour patterns in roles adopted by

professionals were seen as repercussions of cited work pressures and task complexity (Menzies, 1960; Moxnes, 1998). Reflection as to particular difficulty in the Centre's work, and perceived decision avoidances, follows next.

5.2.6.1. Task Difficulty and Decision Avoidances

According to Menzies (1960), 'the success and viability of a social institution are intimately connected with the techniques it uses to contain anxiety' (p. 99). Anxiety-provoking work difficulty in this study was considered in how professionals managed casework that exposed them to the psychological tensions of the parent, in particular the mothers' potential distress and confusion surrounding their young child's difficulties (Lawlor, 2009; Menzies, 1960).

Projections and introjections of these difficult emotions might lead to defensive role routines and basic assumption positioning (Hutton, 1997; Moxnes, 1998). Menzies (1960) writes of defensive practices through depersonalisation and, here, professionals were heard to portray the child impersonally, '((yawns)) we're going to do CHR05'. It seemed professionals use of objective, numerical 'cut-off' scores for diagnosing ASD was a means of avoiding a direct diagnostic decision (Lawlor, 2009; Menzies, 1960): 'So it's... Yeah I think- I think if you say it meets ADOS... Yeah [he does] he meets yeah'.

This is also related to the Keyworker maintaining a centralised role, whilst achieving assessment functions in a shorter frame of time perhaps enabled avoiding closer contact with the child and parent, as might happen from the conduct of regular visits to the home or play setting. For the professional who conducted the Initial Visit (EYPrac/FamCo), this was a single event and requested detail from visits to the child's setting (via SISS professionals), inconsistent (for example, CHR05 assessment concluded with no setting visit information, compared to CHR06 for whom there was more description of child experiences). The assessment using ADOS, found

as a single appointment of mother-child-Keyworker and one other (SISS/EYPrac/FamCo) generated the ‘cut-off’ score. Avoiding discussion maintained a sense of equilibrium, evident when awkward, contested views were suspended and unaddressed (Granville, 2010; Ruch & Murray, 2011) and alternate disciplinary perspectives that might provide questioning the opposite to ‘safe’ decision-making, found absent. This related too, to ‘absconders’ and ‘absentias’ roles, significant in staying away, keeping ‘distance’ or ‘*fleeing*’ (BaF; Bion, 1961) from the real component of the child’s assessment.

Findings showed professionals were thought to ‘split’ (Klein, 1987) the mother, as a figure in their work who might require ‘minding’ to ensure Centre attendance, or alternatively one creating pressure to whom giving reason for the child’s difficulties was necessary. In making this divide, suggestions that having the good version protected the Centre’s purpose where the opposite kind required attention for maintaining this position, allowed professionals to avoid attendant anxieties (Hutton, 1997). This might mean confronting what happens if a decision not to diagnose the child is made or perhaps in evaluating established practices, including appraising the flexibility of their positioning (Bion, 1961; Hutton, 1997; Matthews & Singh, 2015). Approaches in parent-child engagement might thus be reviewed as per guidelines (NICE, 2011; Wood, et al., 2010).

‘Mirroring’ (Mattinson, 1992) is a visible manifestation of challenges in MDT work (Ruch & Murray, 2011). This position was considered in the emotional experiences for professionals, heard in their dialogues as ‘sniffing’, ‘sighing’, frequent uses of the word ‘repetitive’ and speaking in a manner comparable to the child’s attributes: ‘expressive skills consist of mumbling no eye contact no pointing(...) does not mix with children(1) limited smiles but enjoys tantrums’. This susceptibility to mirroring, and reflecting their experience of the work in basic assumption positions, led to a perception that the core team projected outwards, their introjected experiences, of mother-child difficulties and anxieties from abandonment with the difficult task (Hirschhorn,

1988; Hutton, 1997). This potentially, 'pushed away' other, key professionals (absentias/absconders) adding further to the anxious feelings in a cycle that maintained the particular experiences (Hirschhorn, 1988). The theoretical position in this study argues that the role functions of professionals further strengthened this position. Using the reviewed literature, the next section discusses further, how these professional adopted positions could maintain the particular Centre, system experiences.

5.2.6.2. Role Constructions and Professional Position

According to the literature, adopting roles detracts from work purpose (Benne & Sheats, 2007; Moxnes, 1999) and formal roles may be confounded by informal positions (Hare, 2003).

The constructed roles seen through the conduct of the MDT were relative to their observed functions and, regarding the core team, it is argued these were an image wished to be conveyed (Kivisto & Pittman, 2013). The SLT (controller) as Centre Manager performed actions expected from one leading system processes. The EP (guardian) acted to maintain oversight of the Under 6 cases by keeping the spread sheet, which corresponded to a position as Team Lead. The Manager for SISS (pacifier) kept relations going, providing some continuation of the Centre as an organisation (Armstrong, 2004; Moxnes, 1999). In the event of decisions, EP and M, with SISS deferred to the Centre Manager, 'so school have referred to us so (1) if you're happy with that SLT?...' and the perception of fluctuations in BaD seemed relevant alongside fluxes in BaP (Bion, 1961; French & Simpson, 2010).

Whilst these three core functions were preferred for maintaining system processes over using specialist field knowledge, arguably the role differences also occurred in respect of disciplinary backgrounds. Hence, a health trained speech and language therapist taking a lead position, an EP

assuming a guardian role, akin to the professions acknowledged 'protector' of vulnerable children, and a teacher adopting an educative, middle ground.

Previous findings showed decisions in MDTs occurring from individual persuasiveness and personality (Rose, 2009) and Reed argued role in an organisation becomes an 'idea in the mind' responsive to the surrounding situation (2001, p. 3). The Specialist Teachers and Early Years professionals took support roles to the Centre, core team that appeared relative to their position. In respect of a context where status could be seen to hold significance and an uncovered primary purpose to decision-making (Zagier Roberts, 1994b) involved diagnosis of the child, this saw these 'bystander'¹⁸ roles adopting influential positions (Matthews & Singh, 2015). This was either tacit or, unquestioningly in support of the status quo, or vocal encouragement reinforcing decisions leading to diagnosis, 'Mm, he does...]... Mom's very very very anxious'.

Findings for fringe role positions (absentias, absconders) showed these members removed from a child's core assessment and explanation for anxiety effects significant. Team role functions potentially closed the Centre's system and 'pathway' from diverse influences. Maintaining processes despite absent professional contributions and/or contextual limitations, seemed to enable professionals to 'filter out' aspects that might affect their prevailing, collected sense (Boyce, 1995, p.132). Particular internal phraseology (Kivisto & Pittman, 2013), denoting the nature of assessment work included regular, in vivo (Charmaz, 2006) terms, 'hitting a few things', 'job done', '...repetitive...', 'cut off'. Expressions reinforcing distance from the emotional reality inherent in their task, saw the core team count out children in ordering ways: 'we're going to do...', 'who's having that one?', 'right, what's this next one?'

The understanding here, saw these internal discourses representing the singular, objective 'within-child' perspective to assessment practice (Matthews & Singh, 2015), adding further to

the perception of a system effective in filtering out contradictions to the established collective sense (Boyce, 1995).

5.2.7. Implications and Summary

The last section presented an explanation for findings, in context of the literature. Professionals provided a local ASD diagnostic service with a medical model explanation. Diagnostic decisions were the main outcome. Findings were interpreted according to the MDT literature and psychoanalytic concepts (Hollway, 2011), explaining decision-making processes affected by the referral system of the Centre.

The literature emphasises anxiety as a problem for MDT professionals (Anning et al., 2006; Hudson, 2002; Rose, 2009; Sloper, 2004). This study, of mixed MDT (ASD) child assessments, interprets such anxieties as due to the complex nature of the task these teams face (Armstrong, 1997). Findings were interpreted in the context of Bion's (1961) theory on experiences in groups, and represent a credible means by which to understand why it may be difficult for the three (EHC) professional disciplines to work together.

Decision-making had certain limitations. Information and professional 'voices' were absent, meaning a fragmented MDT. The particular team's experience was perceived as 'abandoned'. Findings revealed a system closed to external influence (Boyce, 1995). The social discourses used by professionals suggested that using the three disciplinary EHC foci could open this closed Centre system, introducing new language, meanings and diversity (Matthews & Singh, 2015). Facilitating the engagement of EHC perspectives in this kind of assessment work might allow a fuller exploration of permutations of a child's strengths and difficulties, consistent with

triangulation of evidence (Boddy et al., 2006; NICE, 2011) and diversifying the work experience.

Framing the decision-making of professionals with psychoanalytic literature allowed deeper explanation of the revealed themes: concepts such as primary versus existential tasks, basic-assumption group activity versus productive work group mode, and recognition of defensive practice routines as protection against feelings of anxiety and abandonment during difficult tasks. Whilst there may be resistance to these concepts, their potential to explain the system functions of the professionals represents a non-threatening formulation whereby organisational development may be explored, for example, using ORA (Hutton, 1997; Reed & Bazalgette, 2006) and/or positioning theory (Matthews & Singh, 2015). This was consistent with the study purposes: enhancing learning and change through research activity (Cohen et al., 2007; Parker, 2002).

Reflections on primary task definitions and purposes (Zagier Roberts, 1994a), role clarity, ‘boundaried’ role contributions (Hirschhorn, 1988) and productive work group functioning (Bion, 1961) were shared with the MDT.

The next section considers the strengths and limitations of the study, with reflections on the EP contribution and recommendations for further study in the field of MDT child assessment. Final conclusions are made.

5.3. RESEARCH VALUE

5.3.1. The EP Contribution

This section considers the role of the EP in a Children's Services neurodevelopmental MDT, and the role of EP researcher and potential biases.

5.3.1.1. EP as MDT Practitioner

Findings about the boundary of this particular professional MDT system on role contributions related to individual positioning. Routine work functions towards system maintenance were preferable than using field specialism. The medical model dominated as the preferred means of understanding the child. Professionals resisted diversity, including EP perspectives where the source of most alternative discussions came, for example, observing the young age of CHR02, highlighting the trend for increasingly younger referrals (see text exemplars, pp. 92, 118) and focusing on the task when discussions diverged. Difficult dynamics, evident in dialogues, featured particularly in exchanges between the Centre Manager (SLT) and the EP, with the EP's view often overridden (Boyce, 1995), 'close.'...[we're closing?... 'close.']

Working across diverse fields has been described as a difficult 'neither-nor' experience (Akkerman & Bakker, 2011). The EP role was positioned at the boundary between an EP-constructivist epistemology and a medical, cause-effect model (Fox, 2003). Engagement at a boundary does not mean homogeneity, but 'a process of establishing continuity in a situation of sociocultural difference' (Akkerman & Bakker, 2011, p. 152). An EP working at the boundary of a medical model thus challenged the system by using a social model of disability (Bartolo, 2001; Fox, 2003). The advantages of new ways of working in MDTs have been described (Leadbetter, 2006) and the EP role introduces diversity to the purely medical, within-child focus.

In order to address the avoidance processes revealed in these findings, it is suggested that MDT members understand the effects of projection, mirroring and splitting (Bion, 1961; Moxnes, 1999). The EP role may also 'contain' (Bion, 1962) by encouraging team members to recognise and resolve such recurring issues.

5.3.1.2. EP as Researcher

The professional knowledge and assumptions of the EP researcher informing the findings have previously been described (section 1.5, page 20). Reflections (Charmaz, 2006) involved thoughts, ideas and questions during the conduct of the study, generated by this position (see Appendix 7.4.4. and 7.4.5, pp. 223-231, 238-252).

Where data analysis and interpretation coalesce, self-reflection is important (Cohen et al., 2007; Willig, 2012). A common limitation to CGT is potential bias in researcher constructions of data. Shaw (2010) argues that a researcher may occupy an expert position in the way data categorises and theory generates. Reflexivity involves acknowledging biases and conflicts, and their effects on data coding. In this regard, the researcher's preconceptions as to the kind of assessments these child cases might receive, including preconceived ideas about how EHC disciplinary contributions might occur, might have influenced findings. Being flexible about emerging data and adhering to CGT procedures to construct the theory from this data minimised professional bias and allowed more credible interpretations (Charmaz, 2006).

Reflections included being aware of transference (Hollway & Jefferson, 2013; Parker, 2002). The researcher found the passage of time significant whilst gaining ethical approval and consent, and a loss of sense of time featured in the data analysis. Mirroring and transference caused difficulties with momentum during data capture and created a sense of being 'pushed away' (see reflexive notes, pp. 224-225), as well as feelings of being overwhelmed during analysis (see section 3.6.1, pp. 60-61 and reflexive notes, pp. 228, 229). Basic assumptions, including the

apparent inability to think, 'development is arrested and the resultant stagnation is widespread' (Bion, 1961, p. 128), seemed transferred, with the researcher experiencing a sense of 'being unable to think or to find a new thought in the moment' (French & Simpson, 2010, p. 1868). Reflexivity meant holding the awareness to these challenges to maintain focus (Buckner, 2005), in Charmaz's terms 'learning to tolerate ambiguity' (2007, p. 28), facilitating emergence of the theory.

Research is important for EPs and their client groups. This study highlights practicalities for EPs as professional practitioners involved in research. Real-world challenges obtaining consent and managing unforeseen events, including missed data capture opportunities, endangered the research. Such eventualities may occur during any research. Part of the endeavour is managing these difficulties and keeping sight of the final research product.

5.3.2. Strengths and Limitations of the Study

This section summarises methodological strengths and limitations. Future research is considered.

5.3.2.1. Design and Method

The qualitative methodology meant a more valid representation of MDT joint work. CGT was particularly beneficial for its greater flexibility in coding procedures compared with other GT approaches (Charmaz, 2006). Discussion transcripts presented using a natural text format captured the richness in exchanges, enhancing validity and retaining a stronger sense of the processes (Charmaz, 2006). Transparency and clarity over content strengthened credibility and reliability.

However, this study sample was small and specific to one MDT and six child cases. Whilst case study designs may limit generalisability and increase observer bias, they provide a detailed knowledge of a small number of related cases not possible in large-scale research (Cohen et al., 2007). Psychoanalytic knowledge is based on single cases, and enriched the findings (Hollway & Jefferson, 2013).

Interpretive paradigms derive an understanding of subjective human experience through theory construction, rather than hard, objective reality (Charmaz, 2006). The unexpected may emerge in analysis, and what does is itself researcher “constructions”, ‘we choose the words that constitute our codes’ (Charmaz, 2006, p. 47). The theoretical position adopted in this study therefore, is a possible explanation to the findings provided to further enrich the literature on MDTs in child assessment services.

5.3.2.2. Trustworthiness: Catalytic validity

Research is only as good as the investigator (Morse et al., 2002). The particular EP researcher thus limited the generalisability and validity of these findings. Interpretations were influenced by the subjectivity, knowledge and perspective of the researcher (Cohen et al., 2007). The use of CGT minimised such limitations. Validity was achieved by iterative cycling and constant comparisons (Morse et al., 2002). Constant recycling processes allowed categories to emerge rather than be predetermined, more accurately reflecting the reality (Charmaz, 2006). Peer supervision provided a further validation of codes.

In addition to official notice (see appendix 7.3.2.1, pp. 205-207), these findings were shared with the Centre, both to acknowledge their support in participating and to give them the opportunity to benefit from the research (Charmaz, 2006; Cohen et al., 2007). It was important to link

professional practice at this Centre with the empirical literature and guidance documents. The researcher remained sensitive to the Centre's perspective on the findings.

5.3.3. Future research

This study raises suggestions for future research:

- i) What are the consequences of three EHC disciplinary approaches working together? Bion's (1961) theory might prove a valuable framework for such inquiry.
- ii) The discourse of professionals during their review of the child responses to ADOS assessment could be further analysed. ADOS might be further investigated as an assessment tool, especially in terms of its diagnostic outcomes (see Gardner, 2000).
- iii) What are the child's personal views and wishes, as well as their parents'? (NICE, 2011). How might the MDT better assess these? Various opportunities for assessing the views and wishes of non-communicative children could be explored (Franklin & Sloper, 2009; Glaser, 1996; Hall, 1996).
- iv) What are the effects of NICE guidance on the operation of a Children's Services MDT system? How do other Children's Service MDTs operate? A substantive theory of such social practices could be developed (Glaser, 2007).

Finally, the emergence of system-adopted roles in professional practice as mechanisms of avoidance could be further explored.

5.4. CONCLUSION

Have the aims of this study been achieved? Qualitative methodology was employed to investigate professional MDT decision-making processes affecting child outcomes. Such methods allowed documentation of real world practice processes.

Findings indicated avoidance processes, an absence of professional views, and the potential for missing contextual information pertaining to children — all affecting the decision-making processes in this context. MDT work was fragmentary. There was a singular, medical model approach to understanding the child, which undermined MDT collaboration. Child outcomes centred on diagnosis.

The study highlights significant influences on decision-making practice in mixed MDT work, including absence and avoidance of task commitment. Using psychoanalytic concepts provided a framework of understanding according to which a formula for organisational development and change was generated.

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Consent:	
1. Consent for this Referral: (<i>Informed consent in this section must be obtained before submitting a request for a referral</i>)	
<i>The [redacted] Centre provides services for children with complex medical and developmental needs and their families. For some children this may involve an assessment to investigate underlying causes of difficulties including the possibility of an Autism Spectrum Disorder.</i>	
I/We give consent for a referral to be made for the above named child to the [redacted] Centre Service	
Signed:	
Relationship to child:	Date:
2. Consent to gather and share information	
<i>In order to provide a good service for you and your child we may need to collect information from any professionals currently involved with your child, for example your child's school, Social Worker, Health Visitor or Paediatrician. We will use the information to help us gain a complete picture of your child as part of the assessment process. The information will not be shared with anyone else unless you give permission or we are required to do so by law.</i>	
I/We give consent for information to be collected from important people currently involved with the above named child.	
Signed:	
Relationship to child:	Date:
Why are you referring this child? (Please refer to referral criteria on final page.)	Please tick
1. To request involvement of the Specialist Under 6 Service for children with significant and complex medical and/or developmental needs including difficulties that may indicate the possibility of an Autism Spectrum Disorder.	
2. To request Specialist Assessment of a child Over 6 presenting with difficulties that indicate the possibility of an Autism Spectrum Disorder.	
3. To request Social Care involvement for children with significant and complex medical and/or developmental needs.	
Summarise your main concerns	

Is this child attending or on a waiting list for a school or any other setting e.g. childminders/playgroup?		
Name of Setting/School:	Type of Setting/School:	
Child attend Full/Part Time (please give full details)	Contact person in Setting/School	
Address of School/Setting	Contact No:	
Postcode		
Is this child attending a second setting?		
Name of Setting/School:	Type of Setting/School:	
Child attend Full/Part Time (please give full details)	Contact person in Setting/School	
Address of School/Setting	Contact No:	
Postcode		
People involved with this child: It is also very important that we know details of everyone who has been involved		
Title/Profession e.g. Paediatrician, Social Worker, Health Visitor, other medical, Speech and Language Therapy, Early Years and Child Care, Specialist Inclusion Support Service, Youth Offending Team.	Name and Contact Details	Last known date of involvement
Does this child/family have a 'Team Around the Family' already in place?		
Name of lead person:	Contact No:	

Needs: Please summarise and provide supporting evidence of your concerns in each area of need where possible.			
Areas of strength	Areas of need		
		Gross motor	
		Fine motor	
		Cognitive	
		Visual	
		Hearing	
		Speech and Language (Understanding)	
		Speech and Language (Expressive Skills)	
		Social Communication	
		Attention	
		Play	
		Emotional	
		Behaviour	
		Self Help	
		Flexibility and Adaptability to changes and routines or expectations.	

Any other concerns?						
Any known medical conditions or disability?						
Please comment on the impact of any difficulties described on child, family or setting.						
Family background: Please provide any family information that you feel will be helpful						
Child's Educational Needs						
Is this child on the Special Educational Needs Code of Practice?						
No		Early Years Action/School Action		Early Years + School Action +		Has a statement of SEN
Additional information to support referral						
Please attach any additional relevant information that you may hold e.g.						
<ul style="list-style-type: none"> • Playplans/IEP • Observations and/or Assessments • Any reports previously written • Details of any strategies or interventions • Any general background information 						

Centre Referral Criteria
<p>Social Work Services for severely disabled children</p> <p>The Children's Disability Team provide advice and information, assessment, family support, care packages, access to short breaks, links to other agencies, child protection and looked after children services for families who have a child who:</p> <ul style="list-style-type: none"> • Parents agree to referral • Is aged between 0-18 years old • Child lives in [REDACTED] • Has a disability which has (or is expected to have) a substantial and long term adverse effect on their ability to carry out normal day to day activities; and • Whose health, welfare or development is likely to be impaired without the provision of Specialist Social Care Services. <p>Under 6 service for children with significant and complex medical and/or developmental needs</p> <ul style="list-style-type: none"> • Parents agree to referral • The child is under 6 years of age • The child has a [REDACTED] G.P • Significant delay in two or more areas of a child's development (less than 50% of the child's skills are age appropriate) • Evidence of the impact on a child's functional skills on a daily basis • Failure to make progress as expected in response to any intervention and support • Skill regression or rapidly changing needs • For children 2 years or over, they are at the Early Years Action Plus or School Action Plus Stage of the Educational Code of Practice. <p>Over 6 service for children presenting with difficulties that indicate the possibility of an Autism Spectrum Disorder</p> <ul style="list-style-type: none"> • Parents agree to referral. • The child is aged between 6-18 years old. • The child has a [REDACTED] GP. • Evidence that school have consulted with and implemented strategies recommended by the Specialist Inclusion Support Service. • There are significant and longstanding difficulties in the 3 areas of impairment that indicate the possibility of an Autism Spectrum Disorder: Social Interaction, Communication and flexibility of thought and behaviour. • Evidence that the child would benefit from this highly specialist diagnostic assessment for the possibility of an Autism Spectrum Disorder.
Submitting your referral
<p>Please send all information and referral form to:</p> <p>Administration Team [REDACTED] [REDACTED] [REDACTED]</p> <p style="text-align: right;">Tel No of Centre: [REDACTED] Fax No of Centre: [REDACTED] Email: [REDACTED]</p> <p>Copies of this form are available from [REDACTED]</p>

7.1.2. Parent: Forms of Consent

Copies of parents Invitation letter, Study information, FAQs and Consent form (pp.185-188).

Content of Letter of Invitation to support the study (Parent)

Dear (Name of parent/ carer),

A study into the processes used by different professionals at the (name of centre), in meeting the assessment needs of children 0-6 years who are referred for support for particular neurodevelopmental difficulties.

The (Name of Centre) is carrying out some research into the services it provides for children and their families and is asking you if you would like to take part.

Before you decide, we would like you to understand what will happen.

The research will involve recording the discussions that professionals have about your child, which will help us decide what is working well and what we need to change to help us work more effectively. This research project has been reviewed by an NHS Research Ethics Committee to protect your interests and is covered through the NHS indemnity scheme.

You can choose if the discussions held about your child are recorded or not and whichever way you decide, it will not affect the service offered to you or your child. If you do decide to take part, all information recorded will be confidential. No individual child, parent or professional will be identified or identifiable in the research report.

One of our team will go through the information sheet with you during a home visit or assessment appointment and answer any questions you have. We suggest this should take about 20 minutes. If after this, you have further questions please talk to the researcher, (name) (Tel. Number) or myself, the (Name of Centre) Clinical Manager (Tel.Number).

If you do not wish for your child's discussions to be considered for this research and do not wish to be contacted again about this, then please let us know by telephoning us on (Centre tel.no.) by (date).

Yours sincerely,

(Ends with names/ contact details)

ER/SH/PC.18/08/2011

Information Sheet provided to Parent/Carer

Parent/Carer study information sheet

A study into the processes used by different professionals at the (name of centre), in meeting the assessment needs of children 0-6 years who are referred for support for particular neurodevelopmental difficulties.

You are being invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information.

Do not hesitate to contact us if there is anything that is not clear or if you would like more information. Please use the contact details at the end of this sheet.

What is the purpose of the study?

The purpose of the study is to find out what processes are used by professionals when they work to meet the assessment needs of children 0-6 years, when they are referred for professionals support. The Local Authority and the NHS would like to find out what is working well and whether anything can be improved in order to meet the needs of children and their families. The study will take two years to complete.

Why have I been chosen?

You have been chosen because your child is aged 0-6 years and has been referred for assessment and support by the professional team involved at the centre taking part in the study. You are in a position to be able to consent to recordings being made of the professionals' discussions about your child and the difficulties he/she may have.

Do I have to take part?

It is up to you to decide whether or not to take part. If you would like to take part, you will be given this information sheet to keep and be asked to sign a consent form.

If you change your mind, you are still free to withdraw at any time and without giving a reason.

A decision not to take part or to withdraw later, will not affect the service you or your child receive at the Centre.

What will happen to me if I take part?

You or your child will not be directly involved or affected by this research. The usual assessment procedures at the (name of Centre) will continue to apply in the same way for you and your child.

The research will record the professionals' discussions, in the (name of centre) as they concern your child. These recordings will then be analysed in order to understand better how professionals from different specialisms work together when thinking of the needs of children with complex difficulties. The discussion recordings will be on audio and/or video tape and then transcribed for the analysis.

After transcription is complete, all original recordings will be deleted.

If you should change your mind about taking part later, you can ask for your child's transcript to be removed from the study.

What are the possible benefits and risks?

You may not benefit directly from the research, however it is hoped that overall, children with the type of difficulties experienced by your child will benefit from this research as it will contribute to the development of professionals' assessment and support practices.

No risks have been identified, however if you find that you have any concerns after you have given consent, please talk about these with the Researcher (see contact details below). Arrangements can also be made for you to discuss this with an appropriate staff member from the (name of centre).

What if I have a complaint?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please discuss this with the researcher (contact information below).

If you are still unhappy, please contact (Name), Centre Clinical Manager, (contact information below).

The (Name of Centre) normal complaints procedures will still be available to you.

Will my taking part in this study be kept confidential?

Your person-identifiable details are stored under the (Name of Centre)'s usual arrangements, in accordance with the Local Authority and NHS data protection policies. If you join the study, your child's name, gender, age and their difficulties can be looked at by the researcher who will have a duty of confidentiality to you.

This information collected during the course of the research will be kept strictly confidential. Your names, your child names, and any personal details will be removed from all information so that you cannot be recognised from it.

After transcription is complete, all original audio/video recordings will be deleted. The transcripts will be deleted and/or destroyed, when the research and publications of its findings are completed.

What will happen to the results of the research study?

The main findings will be presented to the professionals at (Name of Centre) and to the Local Authority Educational Psychology Service.

A summary of the findings of the research will be available on request, via the (Name of Centre). If the findings are particularly relevant they may be publishable and if so, you or your child will not be identifiable in any report or publication.

Contact for Further Information

Please contact **(name)**, Educational Psychologist for more information on **Tel. Number** or **(Name)**, Centre Manager on **(Tel.No.)**

Thank you for reading this information.

Ref: ER/MC/PC.18-08-2011

Copy of Consent Form (Parent/Carer)

(Form to be on (Name of Centre) headed paper)

Centre Number: (No tbc)
 Study Number: IRAS [REDACTED]
 Participant ID No:

CONSENT FORM

Title of Project: *A study into the processes used by different professionals at the (name of centre), in meeting the assessment needs of children 0-6 years who have been referred with neurodevelopmental difficulties.*

Name of Researcher: (name)

Please initial box

1. I confirm that I have read and understand the invitation letter (ER/SH/PC.18/08/2011) and information sheet (ER/MC/PC.18-08-2011) for the above study and have had the opportunity to consider the information and ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without mine or my child's care being affected
3. I agree to take part in the above study.

 Name of Participant.

 Date

 Signature

 Name of person taking consent.

 Date

 Signature

When completed, 1 copy each to Participant, Researcher file and (Name of Centre) records.

Ref: ER/CF-PC.18/08/2011.

7.1.3. Professional: Forms of Consent

Copies of professionals Invitation letter, Study information, FAQs, Consent form and Presentation handout, (pp.189-194).

Content of Letter of Invitation to support the study (Professional)

Dear (Name of Professional),

A study into the processes used by different professionals at the (name of centre), in meeting the assessment needs of children 0-6 years who are referred for support for particular neurodevelopmental difficulties.

We are currently supporting a piece of research into the services provided for children referred to our centre and are asking for you to take part. Before you decide, we would like you to know what will happen and what it will involve for you.

You will be presented with a summary of the research details during our staff meeting, with also an Information sheet with further details for you to read, and a copy of this letter requesting for your involvement. If you have any questions, please ask us.

The research will involve audio and/or video recordings of the Under-6 team's mixed professional discussions in relation to some child referrals and is being undertaken with the aim to develop our practice to meet the needs of these children even more effectively. We wish to identify both what is working well and what may need to be improved. It is hoped that the findings can be published and may usefully contribute toward the growing evidence base of 'what works well' in assessment services for children with neurodevelopmental difficulties.

The research project has been reviewed by an NHS Research Ethics Committee to protect your interests and is covered through the NHS indemnity scheme. All information shared will be confidential and no individual will be identified or identifiable in the research report or in published reports.

Your participation is entirely voluntary and you can choose whether or not you would like to take part and this will not affect your work at the Centre.

If you would like to take part, please return the reply slip below, to (name, Researcher) using the reply-paid envelope provided.

Yours sincerely,
(Ends with names/ contact details)

✂.....

A study into the processes used by different professionals at the (name of Centre), in meeting the assessment needs of children 0-6 years referred for support for particular neurodevelopmental difficulties.

I am willing to take part in the above study and understand I will be contacted further to give my signed, informed consent.

Name: _____ Date: _____

ER/SH/PF.3_23/09/2011

Information sheet for Professionals

Professional study information sheet

A study into the processes used by different professionals at the (name of centre), in meeting the assessment needs of children 0-6 years who have been referred with neurodevelopmental difficulties.

You are being invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information.

Do not hesitate to contact us if there is anything that is not clear or if you would like more information. Please use the contact details at the end of this sheet.

What is the purpose of the study?

The purpose of the study is to find out what processes are used by professionals when they work to meet the assessment needs of children 0-6 years, when they are referred for professional support. The Local Authority and the NHS would like to find out what is working well and whether anything can be improved in meeting the needs of children and their families. The study will take two years to complete.

Why have I been chosen?

You have been chosen because you work at the (name of Centre) in the assessment services for children Under-6 who have been referred for neurodevelopmental difficulties. You are in a position to consent to have recordings made of professional discussions related to some specific children and the difficulties they have.

Consent for these discussions to be recorded will have been obtained from the individual child's Parent/Carer. If you wish to see the information provided to Parent/Carers, this can be made available to you.

Do I have to take part?

It is up to you to decide whether or not to take part. If you would like to take part, you will be given this information sheet and summary to keep and be asked to sign a consent form.

If you change your mind, you are still free to withdraw at any time and without giving a reason.

A decision not to take part or to withdraw later, will not affect your work at the Centre.

What will happen to me if I take part?

You will not be directly affected by this research. The usual professional assessment procedures at the (name of Centre) will continue to apply in the same way for you.

Professional discussions, as they concern a child, will be recorded and analysed in order to understand better how professionals from different specialisms work together when thinking of the needs of children with neurodevelopmental difficulties.

The discussions will be audio and/or video recorded and then transcribed for the analysis. After transcription is complete, all original recordings will be deleted.

If you change your mind about taking part later, you can ask for the transcript of your involvement to be removed from the study.

What are the possible benefits and risks?

You may not benefit directly from the research, however, it is hoped that overall children with the type of difficulties as are referred at the Centre will benefit from this research as it can contribute to the development of professional assessment and support practices. Professionals and this may include you, can benefit from the contribution this research hopes to make, in sharing of most effective practices in the field of child assessment services.

No risks have been identified, however if you find that you have any concerns after you have given consent, please contact the researcher to discuss this (see contact details below). Alternatively, you may wish to speak with (name of centre manager).

What if I have a complaint ?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please discuss this with the researcher (contact information below).

If you are still unhappy, please contact (name of centre manager).

The (Name of Centre) normal staff complaints procedures will still be available to you.

Will my taking part in this study be kept confidential?

All information collected during the course of the research will be kept strictly confidential and any data will be stored in accordance with the Local Authority and NHS data protection policies. If you join the study, your name and professional specialism will be available to the researcher, who will have a duty of confidentiality to you.

Your name will be removed from all information where it may appear so that you cannot be recognised from it.

After transcription is complete, all original audio/video recordings will be deleted.

The transcripts will be deleted and/or destroyed, when the research and any publication of its findings are completed.

What will happen to the results of the research study?

The main findings will be presented back to all professionals at (Name of Centre) and to the Local Authority's Educational Psychology Services. A summary of the findings of the research will be available on request to Parent/Carers, via the (Name of Centre).

If the research findings are particularly relevant they may be publishable and if so, you will not be identifiable in any report or publication.

Contact for Further Information

Please contact **(name)**, Educational Psychologist for more information on **Tel Number** or **(Name)**, Centre Manager.

Thank you for reading this information.

Ref: ER/MC/PF.18-08-2011

Copy of Consent Form (Professional)

(Form on (Name of Centre) headed paper)

Centre Number: (No tbc)
 Study Number: IRAS [REDACTED].
 Participant ID No:

CONSENT FORM

Title of Project: *A study into the processes used by different professionals at the (name of centre), in meeting the assessment needs of children 0-6 years who have been referred with neurodevelopmental difficulties.*

Name of Researcher: (name)

Please initial box

1. I confirm that I have read, and understand the invitation letter **(ER/SH/PF.18/08/2011)** and information sheet **(ER/MC/PF.18-08-2011)** for the above study and have had the opportunity to consider the information and ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my work at the (Name of Centre) being affected.

3. I agree to take part in the above study.

 Name of Participant.

 Date

 Signature

 Name of person taking consent.

 Date

 Signature

When completed, 1 copy each to Participant, Researcher file and (Name of Centre) records.

Ref: ER/CF-PF.18/08/2011.

Presentation hand-out of the study purpose for Centre professionals.

ER/ppt.1 10-01-2011

A study into the processes used by different professionals at the (name of centre), in meeting the assessment needs of children 0-6 years who have been referred with neurodevelopmental difficulties.

A study for the award of

Professional Doctorate in Educational Psychology

The Tavistock and Portman NHS
Foundation Trust in Partnership with
University of Essex.

1

What is it about...?

- to explore the psychological processes that support the joint decision-making practice of child professionals, in early years team assessment services for children with neurodevelopmental difficulties.
- qualitative study : using grounded theory to analyse the recorded discussions of multi-disciplinary team members, in respect of some individual child case studies, as referred to this child development assessment centre.
- emergent theory: hopeful that it can assist in the formulation of a framework to promote effective multidisciplinary team assessment practices for children.

2

Why...?

- Political context promoting integrated working (e.g. *Every Child Matters*, DfES, 2003; *Children Act*, 2004; *Aiming high for disabled children: better support for families*, DfES, 2007; *Equity and Excellence: Liberating the NHS*, DH, 2010).
- Focus on what it actually looks like in reality... with equivocal evidence that it improves child outcomes ... an emerging picture of how it can work well (e.g. recent large-scale projects: Anning, et al 2006; Leadbetter, et al. 2008.)

3

Researcher's position

An Educational Psychologist from (name) EPS

1. *Unknowing*...
2. Exploration of effective MDT practice in assessments for children with neurodevelopmental difficulties
3. To research decision-making & impact when educational, social & medical professionals work together directly...(hereafter called *mixed MDT*)
4. ... so an exploration of the processes of mixed MDT working (previous research has studied team decision-making & impact according to professionals from specific educational, social or medical orientation i.e. Not 'true' *mixed disciplinary*)
5. To describe any emergent framework of practice for mixed MDT children's assessment services
6. To inform of MDT (including EPs) practice, when in the context of mixed MDTs

4

7.2. SUMMARIES OF LITERATURE REVIEWS

7.2.1. Preliminary Search (1): Joint Working in Children's Services

Search terms, as entered: (*joint working OR collaborative working OR multi-disciplinary OR interagency OR multiagency professionals*) AND (*team OR workgroup OR group*) AND (*Children's Services OR services AND children*) AND (*practice OR working practice OR theoretical model OR outcomes OR processes*)

Databases: *PsychLit, Ingenta, Emerald Insight, JSTOR, EBSCO, PEP Archive, Web of Science and ProQuest.*

Inclusion criteria: UK based, from year 2000, related for Children's Services and included mixed professional teams with an emphasis on EP involvement

<u>Author</u>	<u>Year</u>	<u>Title and Journal</u>
Anning, A Cottrell, D Frost, N Green, J Robinson, M	2006	Developing Multi-professional teamwork for integrated children's services: Research, policy and practice. <i>Book</i>
Bachmann, M. O O'Brien, M Husbands, C Shreeve, A Jones, N Watson, J Reading, R Thoburn, J Mugford, M	2009	Integrating Children's Services in England: national evaluation of children's trusts. <i>Child: Care, Health & Development</i>
Bartolo, P.	2001	How disciplinary and institutional orientation influences professionals' decision-making about early childhood disability <i>Educational and Child Psychology</i>
Bartolo, P. Dockerell, J. Lunt, I.	2001	Naturalistic decision-making task processes in multiprofessional assessment of disability. <i>Journal of School Psychology.</i>
Boddy, J Potts, P Statham, J	2006	Models of good practice in joined-up assessment: working for children with 'significant and complex needs' <i>Institute of Education. Thomas Coram Research Unit</i>
De Bere, S.	2003	Evaluating the implications of complex interprofessional education for improvements in collaborative practice: a multidimensional model. <i>British Educational Research Journal</i>
Forbes, J.	2003	Grappling with collaboration: would opening up the research base help? <i>British Journal of Special Education.</i>

Frost, N.	2005	Professionalism, partnership and joint-up thinking: A research review of front-line working with children and families. <i>Research in Practice</i>
Hudson, B.	2002	Interprofessionality in health and social care: the Achilles' heel of partnership. <i>Journal of Interprofessional Care</i>
Hughes, M.	2006	Multi-agency teams: why should working together make everything better? <i>Educational and Child Psychology</i>
Leadbetter, J.	2006	New Ways of Working and New Ways of Being: Multi-agency Working and Professional Identity. <i>Educational and Child Psychology</i>
Leadbetter, J.	2008	Learning in and for interagency working: making links between practice development and structured reflection <i>Learning in Health and Social Care.</i>
McInnes, K.	2007	A practitioner's guide to interagency working in children's centres. A review of the literature. <i>Barnardo's Policy & Research Unit.</i>
Norwich, B. Richards, A. Nash, T.	2008	Children in care and the multi-disciplinary work of educational psychologists. <i>AEP Publication</i>
O'Brien, M. Bachmann, M. Jones, N. Reading, R. Thoburn, J. Husbands, C. Shreeve, A. Watson, J.	2009	Do Integrated Children's Services Improve Children's Outcomes?: Evidence From England's Children's Trust Pathfinders <i>Children and Society.</i>
Orelove, Sobsey, Silverman	2004	Educating children with multiple disabilities. A collaborative approach. <i>Book</i>
Robinson, M. Cotterill, D.	2005	Health professionals in multi-disciplinary and multi-agency teams: Changing professional practice. <i>Journal of Interprofessional Care.1</i>
Sloper, P.	2004	Facilitators and barriers for co-ordinated multi-agency services <i>Child Care Health and Development.</i>
Warmington, P Daniels, H. Edwards, A. Brown, S. Leadbetter, J. Martin, D. et al	2004	Learning in and for interagency working. Interagency collaboration: a review of the literature. <i>Birmingham University</i>
Wilson, V. Pirrie, A.	2000	Multidisciplinary teamworking: Beyond the barriers? A review of the issues. <i>Scottish Council for Research in Education</i>

7.2.2. Preliminary Search (2): Working in Groups/Teams

Search terms, as entered: (*services OR children OR Children's Services*) AND (*effective teams OR team dynamics OR group communication OR outcomes review OR decision making OR effective meetings*) AND (*group OR working in groups OR Workgroup Teams OR Project group OR group psychology*).

Databases: *PsychLit, Ingenta, Emerald Insight, JSTOR, EBSCO, PEP Archive, Web of Science and ProQuest*

Inclusion criteria: Dating from 2000 in services for children, and with an emphasis on EP involvement, led to one specific study of relevance found (Billington, 2006).

Broadening the range of literature, involved modified search parameters including organisational studies (rather than specifically Children's Services) using research pre-2000 where relevant, UK/International based, in the Work and Organisational field.

<u>Author</u>	<u>Year</u>	<u>Title and Journal</u>
Allen, N. Hecht, T.	2004	The 'romance of teams': toward an understanding of its psychological underpinnings and implications <i>Journal of Occupational and Organisational Psychology</i>
Barsade, S.	2002	The ripple effect. Emotional contagion and its influence on group behaviour <i>Administrative Science Quarterly.</i>
Barsade, S. Gibson, D.	2007	Why does affect matter in organisations? <i>The Academy of Management Perspectives.</i>
Billington, T.	2006	Psychodynamic theories and the 'science of relationships' (Bion): A rich resource for professional practice in Children's Services <i>Educational and Child Psychology</i>
Brown, A.D. Starkey, K.	2000	Organisational identity and learning: A psychodynamic perspective <i>Academy of Management Review</i>
Buchanan, L. O'Connell, A.	2006	A brief history of decision-making. <i>Harvard Business Review.</i>
Chapman, J.	2006	Anxiety and defective decision-making: an elaboration of the groupthink model. <i>Management Decision.</i>
Dennison, A. McBay, C. Shaldon, C.	2006	Every team matters: The contribution educational psychology can make to effective teamwork. <i>Educational and Child Psychology.</i>
Dion, K.	2000	Group cohesion: From 'field of forces' to multidimensional construct. <i>Group Dynamics: Theory, Research and Practice.</i>
Dorahy, M. Hamilton, G.	2009	The 'Narcissistic-We' model: A conceptual framework for multi-disciplinary team working, researching and decision-making with traumatised individuals. <i>Counselling and Psychotherapy Research</i>

Elstein, A. Schwarz, A.	2002	Clinical problem-solving and diagnostic decision-making: selective review of the cognitive literature. <i>British Medical Journal</i>
Galanter, C. Patel, V.	2005	Medical decision-making: a selective review for child psychiatrists and psychologists. <i>Journal of Child Psychology and Psychiatry</i> .
Hogg, M. Turner, J.	1987	Intergroup behaviour, self-stereotyping and the salience of social categories. <i>British Journal of Social Psychology</i> .
Hogg, M. Williams, K.	2000	From I to We: Social identity and the collective self, <i>Group Dynamics: Theory, Research and Practice</i> .
Kahneman, D. Klein, G,	2009	Conditions for intuitive expertise. A failure to disagree. <i>American Psychologist</i> .
Maitlis, S. Ozcelik, H.	2004	Toxic decision processes: A study of emotion and organisational decision making. <i>Organisation Science</i> .
March, J.	1991	How decisions happen in organisations <i>Human-Computer Interaction</i>
Nickerson, R.	1998	Confirmation bias: A ubiquitous phenomenon in many guises. <i>Review of General Psychology</i> .
Reed, B.	2001	An exploration of role. <i>The Grubb Institute</i> .
Stokes, J.	1994	The unconscious at work in groups and teams. Contributions from the work of Wilfrid Bion <i>Book Chapter</i>
Tversky, A. Kahneman, D.	1974	Judgement under uncertainty: Heuristics and biases. <i>Science</i> .
Wilson, D Timmel, J. Miller, R.	2005	Cognitive Cooperation: When the Going Gets Tough, Think as a Group <i>Book Chapter</i>
Zajonc, R.	1984	On the primacy of affect. <i>American Psychologist</i>

7.2.3. Secondary Literature Search

Search terms, as entered: (*Mother/ mother-figure/ mother role*) AND (*System/s organisation; work/ task; abandonment/ difficulty; decision making; weighing-up; saliency*) AND (*Expediency/ routines/ predictability; continuation*) AND (*Adopted roles/ roles/ work roles; functions*) AND (*Avoidance/s, unpleasantness/ emotions/ emotion/al affect, anxiety; splitting*).

Specific single searches of the terms: controller-guardian-pacifier-bystander-absconder-absentia
Databases: PsychLit, Ingenta, Emerald Insight, JSTOR, EBSCO, PEP Archive, Web of Science and ProQuest

Inclusion criteria: (Year: 2000-2015; Language: English mainly UK based, with pertinent international studies).

<u>Author</u>	<u>Year</u>	<u>Title and Journal</u>
Akkerman, S. Bakker, A.	2011	Boundary crossing and boundary objects <i>Review of Educational Research</i>
Armstrong, D.	1997	The 'institution in the mind': reflections on the relation of psych-analysis to work with institutions <i>Electronic Article</i> and Emotions in organisations: Disturbance or intelligence <i>Book Chapter</i>
Benne, K. Sheats, P.	2007	Functional roles of group members. <i>Group Facilitation: A Research and Applications Journal</i>
Boyce, M	1995	Collective centering and collective sense-making in the stories and storytelling of one organisation <i>Organisational Studies</i>
French R. Simpson, P.	2010	The 'work group': Redressing the balance in Bion's <i>Experiences in Groups</i> <i>Human Relations</i>
Granville, J.	2010	Minding the Group. Group process, group analytic ideas, and systems supervision – Companionable or uneasy bedfellows. <i>Book Chapter</i>
Hare, P.	1997	Types of Roles in Small Groups: A Bit of History and a Current Perspective. <i>Small Group Research.</i>
Hutton, J.	1997	Re-imagining the organisation of an institution: Management in human service institutions <i>Book</i>
Kapur, R.	2009	Managing primitive emotions in organisations <i>Group Analysis</i>
Kvisto, P. Pittman, D.	2013	Goffman's Dramaturgical Sociology: Personal Sales and Service in a Commodified World <i>Book Section</i>
Lawlor, D.	2009	Test of Time. A case study in the functioning of social systems as a defence against anxiety: Rereading 50 years on <i>Clinical child psychology and psychiatry</i>

Mason, C. Griffin, M.	2003	Group absenteeism and positive affective tone: A longitudinal study. <i>Journal of Organisational Behaviour</i>
Matthews, J. Singh, R.	2015	Positioning in groups: A new development in systemic consultation <i>Educational Psychology in Practice</i>
Menzies, I	1960	A Case-study in the functioning of social systems as a defence against anxiety: A report on a study of the nursing service of a general hospital <i>Human Relations</i>
Morgan-Jones, R.	2007	'Retainment' of staff: The challenge to the system in managing the presence or absence of staff for the work task: The application of Bion's approach to group psychosomatic phenomena. <i>Organisational & Social Dynamics</i>
Moxnes, P.	1998	Fantasies and fairy tales in groups and organisations: Bion's basic assumptions and the deep roles. <i>European Journal of Work and Organisational Psychology</i>
Moxnes, P.	1999	Understanding deep roles: A psychodynamic model for role differentiation in groups. <i>Group dynamics: Theory, research and practice</i>
Reed, B. Bazalgette,	2006	Organisational role analysis at The Grubb Institute of Behavioural Studies: Origins and development <i>Book</i>
Rose, J.	2009	Dilemmas of Inter-Professional Collaboration: Can they be Resolved?. <i>Children & Society</i>
Ruch, G. Murray, C.	2011	Anxiety, defences and the primary task in integrated children's services: Enhancing inter-professional practice <i>Journal of Social Work Practice</i>
Suter, E.	2009	Role understanding and effective communication as core competencies for collaborative practice <i>Journal Of Interprofessional Care</i>
Weller, J.	2012	Shedding new light on tribalism in health care <i>Medical Education</i>
Zagier Roberts, V.	1994	The Organisation of work: Contributions from open systems theory, and The self-assigned impossible task. <i>Book Chapters.</i>

7.3. ETHICAL APPROVALS

7.3.1. Sponsor and Academic Approval

(Tavistock & North Central London Research Consortium)

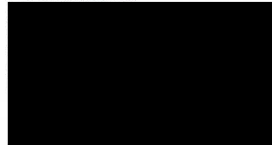
The Tavistock and Portman 
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: 020 8938 2548
Fax: 020 7447 3837
www.tavi-port.org

6 July 2011

Eva Robbins



Dear Eva

Re: Research Ethics Application

Title: How does the Group Psychology of a Children's Service Multi-Disciplinary Team impact on the Decision Making Processes used in Specific Child Assessment Outcomes?

As you already know, your revised amendments were approved by the assessors last month.

I am pleased to let you know, that as Chair of the Trust Research Ethics Committee, I have taken Chair's Action to ratify the approval of your application.

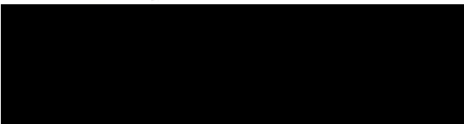
The Tavistock & Portman NHS Foundation Trust is the sponsor of your research as you are a fully registered student with the Trust. Should it be required, the Trust would be willing to provide further details as to what sponsorship entails in this particular instance

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

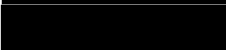
May I take this opportunity of wishing you every success with your research.

Yours sincerely



Research Ethics Committee

(Supervisor)



7.3.2. Research Ethics Approval: NHS



10 October 2011

Ms Eva Robbins
 Educational Psychologist (East)

Dear Ms Robbins

Study title: How does the Group Psychology of a Children's Service Multi-Disciplinary Team impact on the Decision-Making Processes used in Specific Child Assessment Outcomes?

REC reference:
Protocol number:

Thank you for your letter of 30 September 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of

This Research Ethics Committee is an advisory committee to the Yorkshire and The Humber Strategic Health Authority
 The National Research Ethics Service (NRES) represents the NRES Directorate within
 the National Patient Safety Agency and Research Ethics Committees in England

the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter		30 September 2011
Investigator CV		04 October 2010
Letter from Sponsor		06 July 2011
Other: Supervisor's CV		10 August 2011
Other: Professional PPT Presentation Slides		10 January 2011
Other: Invitation Letter to Parent/Carer	ER/SH/PC.3	23 September 2011
Other: Invitation Letter to Professionals	ER/SH/PF.3	23 September 2011
Participant Consent Form: Parent/Carer	ER/CF-PC_2	23 September 2011
Participant Consent Form: Professionals	ER/CF-PF_2	23 September 2011
Participant Information Sheet: Parent/Carer	ER/MC/PC.3	23 September 2011
Participant Information Sheet: Professionals	ER/MC/PF.3	23 September 2011
Protocol	6	18 August 2011
REC application		22 August 2011
Response to Request for Further Information		30 September 2011

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Chair

Email:

Enclosures: "After ethical review – guidance for researchers" [SL-AR2]

Copy to:

7.3.2.1. Progress Reviews



National Research Ethics Service
Health Research Authority
NRES Committee [redacted]

[redacted] office
 First Floor, [redacted]
 [redacted]
 Tel: [redacted]

07 January 2013

Ms Eva Robbins

[redacted]

Dear Ms Robbins

Study title: How does the Group Psychology of a Children's Service Multi-Disciplinary Team impact on the Decision-Making Processes used in Specific Child Assessment Outcomes?

REC reference: [redacted] protocol number: N/A IRAS project [redacted]

Thank you for sending the progress report for the above study dated 02 January 2013. The report will be reviewed by the Chair of the Research Ethics Committee, and I will let you know if any further information is requested.

The favourable ethical opinion for the study continues to apply for the duration of the research as described in the application and protocol agreed by the REC, taking account of any substantial amendments.

[redacted] Please quote this number on all correspondence

Yours sincerely

(, '11

[redacted]
 Committee Co-ordinator

E-mail: [redacted]



Health Research Authority

HRA NRES Centre [REDACTED]

Tel: [REDACTED]
Fax: [REDACTED]

20 March 2014

Ms Eva Robbins

[REDACTED]

Dear Ms Robbins

Study title: **How does the Group Psychology of a Children's Service Multi-Disciplinary Team impact on the Decision-Making Processes used in Specific Child Assessment Outcomes?**

REC reference:
Protocol number:
IRAS project ID:

[REDACTED]

Thank you for sending the declaration of end of study form, notifying the Research Ethics Committee that the above study concluded on 17 February 2014. I will arrange for the Committee to be notified.

A summary of the final research report should be provided to the Committee within 12 months of the conclusion of the study. This should report on whether the study achieved its objectives, summarise the main findings, and confirm arrangements for publication or dissemination of the research including any feedback to participants.

[REDACTED] **Please quote this number on all correspondence**

Yours sincerely

Copy to: [REDACTED]

REC Assistant

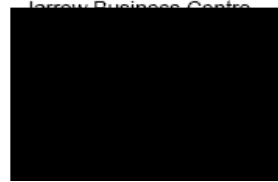
Email: [REDACTED]

A Research Ethics Committee established by the Health Research Authority

Copy to: [REDACTED]



Health Research Authority
NRES Committee Yorkshire & The Humber - Sheffield



20 April 2015

Ms Eva Robbins
Educational Psychologist (East)

[Redacted]
[Redacted]
[Redacted]
[Redacted]
[Redacted]
[Redacted]
[Redacted]

Dear Ms Robbins

Study title: How does the Group Psychology of a Children’s Service Multi-Disciplinary Team impact on the Decision-Making Processes used in Specific Child Assessment Outcomes?

REC reference: [Redacted]
IRAS project ID: [Redacted]

Thank you for sending the summary of the final research report for the above study dated 13 April 2015. The report will be reviewed by the Chair of the Research Ethics Committee, and I will let you know if any further information is requested.

[Redacted] Please quote this number on all correspondence

Yours sincerely

[Redacted signature box]

[Redacted]
REC Assistant

E-mail: [Redacted]

7.3.3. Local Research and Development Approval: NHS

[REDACTED]

Research & Development Directorate

Tel: [REDACTED]
Fax: [REDACTED]

[REDACTED]
Office Hours (Mon-Fri): 09.00 – 17.00

20/10/2011

Eva Robbins
Educational psychology Service

Dear Ms Robbins,

R&D Code: [REDACTED] **Study title:** How does the group psychology of a children's service multi-disciplinary team impact on the decision-making processes used in specific child assessment outcomes?

EudraCT: N/A

I am pleased to inform you that the R&D review of the above project is now complete and has been formally approved to be undertaken at Heart of England NHS Foundation Trust. The following documents were reviewed:

Protocol Version 6.0 18 August 2011

PIS: Parent/Carer ER/MC/PC.3 23 September 2011

PIS: Professionals ER/MC/PF.3 23 September 2011

Consent: Parent/Carer ER/CF-PC_2 23 September 2011

Consent: Professionals ER/CF-PF_2 23 September 2011

GP letter N/A

NHS NRES Application Form Eva Robbins 14 August 2011

NRES Site Specific Information Form Eva Robbins 15 August 2011

NRES Approval Letter 10 October 2011

SSI Approval Letter Incorporated into Trust Approval

MHRA notice of Acceptance N/A

Any Standard Operating Procedures for the Study

Other documents:

Invitation Letter to Parent/Carer ER/SH/PC.3 23 September 2011

Invitation letter to Professionals ER/SH/PF.3 23 September 2011

Sponsor Letter 06 July 2011

... continued ...

The conditions of this approval are as follows:

- 1) You adhere to the approved version of the protocol and notify R&D immediately of any changes to the study, including any new staff working on the project, who may require Trust or Honorary contracts issued.
- 2) You notify R&D immediately of any Serious Adverse Events, including Suspected Unexpected Serious Adverse Reactions (SUSARs)
- 3) You adhere to the requirements of the ethics committee as detailed in their approval letter and standard operating procedures which can be found on www.nres.npsa.nhs.uk
- 4) For CTIMP studies, you adhere to the regulations, including good clinical practice, of The Medicines for Human UK Clinical Regulations (SI 2004/1031; SI 2006/1928; SI 2006/294; SI 2008/941; SI 2009/1164; SI 2009/3063; and SI 2010/1882).
- 5) You notify R&D immediately of any Serious Breaches of GCP or the protocol occurring on this site. This applies to both sponsored and hosted projects. Guidance on Serious Breaches identification & reporting can be found at:
<http://www.mhra.gov.uk/Howweregulate/Medicines/Inspectionandstandards/GoodClinicalPractice/News/CON084915>
- 6) You adhere to the applicable R&D Standard Operating Procedures which can be found on
- 7) You notify R&D on completion of the project
<http://sharepoint/policies/default.aspx> under R&D

The duration of this approval extends to the date specified in the IRAS ethics application form, except where action is taken to suspend or terminate the opinion or should your research not begin within 2 years of the approval date.

Pharmacy


Should your study require the dispensing of drugs, please do not commence work on the project until pharmacy has issued the green light, as per MHRA requirements (<http://www.mhra.gov.uk/Howweregulate/Medicines/Inspectionandstandards/GoodClinicalPractice/Frequentlyaskedquestions/index.htm>). The green light confirms that pharmacy has all procedures and documentation in place and can comply with the medicines management aspects of the study. The pharmacy team will email you the green light approval once the above is in place.

May I also draw your attention to the Research Governance Framework which can be found on the internet http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108962 and remind you that all research within the Trust should be run to the standards as outlined in this document. Guidance and advice is always available from the Department of Research and Development should you require it at any stage of your project. If you have any queries please do not hesitate to contact me.

Yours sincerely



R&D Manager

cc:  – Tavistock and Portman NHS Foundation Trust

7.4. DATA ANALYSIS SOURCES

7.4.1. First, initial 'quick' CGT Codes

<u>Systems</u> :	Page 211
<u>Professional Assessment</u> :	Page 212
<u>Professional Interpretation</u> :	Page 213
<u>Professional Action</u> :	Page 215
<u>Professional Dialogue</u> :	Page 215
<u>Influential dialogic contributions</u> :	Page 216

Facilities

Equipment
 Panel Routine
 Extraneous interference
 protecting children
 Referral form
 Amount of ref. information
 extra emphasis by accomp.letter
 Acknowledgement signature
 Closure
 Team working
 in the loop
 Reason for referral
 Absent professionals
 Working with missing information
 Acting on behalf when absent
 Guessing on their behalf
 Guiding/ training
 Monitoring
 Centre Referrals
 Distorted memory
 Reaching the end (of list)(relief!)
 Increasing
 High numbers
 One after another
 keeping track
 Getting younger
 Knowledge for Locality Bases/ Services
 Referral Procedure/information
 Establishing dateline
 Previously discussed
 If child attends setting
 referral for additional prof opinion
 Referral to SISS
 Referral to audiology
 Waiting list - Prof KWkr allocation
 Personal details check
 Clarifying age
 Prof.specific
 TaviResearch influence
 Recording discussion
 Altrntv from reg form filling (visit record)
 recording decision
 Proceed to full assmnt
 ASD a possible factor
 Initial visit
 date recording
 Inconsistency
 Child Known
 to Paediatrician
 In a setting
 - to Centre Profs
 Not met before
 Frequency of time with child
 - to SISS
 Own database/recording system
 Overlooked
 Home visit completed
 Gaps in records
 - to GP
 - to ReferrerStatus of Referrer
 School
 GenPrac
 Paediatrician
 SLT
 SISS

Time issues

Making time
 Official Time Clock (ticking)
 Efficiency matters
 Disrupted schedule
 Planned use of time
 Keeping task focus
 Length of time it takes
 Parent cancellations
 Tactical delaying
 Recency of visits
 Never ending
 Multi-tasking Caseload
 Overlapping appointments
 Short notice
 fitting in prof discussion appts
 No time
 Effects cutting corners
 Recording factors
 Duplication
 ToSendOutLetter
 Informing parents
 Colour coded
 highlights recurrences
 All paperwork has purpose
 Informing relevant professionals
 Clarifying who's not involved
 Feedback to referrer
 in reasonable timeframe
 Via Admin
 Handwritten record
 Procedure not followed
 Computer systems
 Logging profs
 Managing/operating the spreadsheet
 recording actions taken
 Checking date accuracy
 Locating/previous input on database
 Using name with date
 Using date information
 To support Joint working
 Info. kept in child file
 Prioritisation
 Identifying other professionals
 SaLT input?
 Prof. KWkr Allocation
 Child's age means no rank order
 Starting school
 Locality requirements
 Team Mngr priority
 On hold/ Close
 Consents
 Further info
 Team Mngr influence
 Unable to continue w/oTmMngr
 Management recommendation
 Managing risk
 Planning and Review
 Identified loopholes
 Review/ check decisions
 Decision to accept referral
 Not to do Full Assmnt
 From school's referral
 Based on family history
 Following feedback from SISS visit
 Based on Referrer status
 Is Early Intervention/ A good thing

	Value of note-taking
Political correctness	In Setting
Locality diagnosis	school reported concerns
University research	from Sp Tchr
indications of ASD	Visit outstanding
Child physicality	At Home
Size	Parent/Family Factors
Age comparison	Parent self-diagnosis
Liaison	Father's involvement
Reports from SISS	Assumptions about contact
from home intervention	Profs knowledge of parents
from nursery visits	Family
Outstanding information	New sibling
Telephone	Sibling with Dev.delay
with SaLT	Sibling with ASD diagnosis
with Health Visitor	Influences pnt percptns about play
with SISS	Different presentations
With Mother	Previous service user
Making the Plan	Recalling previous meeting
needs based & irrespective of ASD diag criteria	Extended family influence
Seeing the assessment end	Family Living
Obtaining knowledge of Child	Crowded
Interprof. collaboration	Home description/location
Info.sharing/ communication	Parent relations
Social Worker	Unsupportive
Implied unreliability	Supportive
Frequency of contact	Factors relating to Mother
SaLT	Religious beliefs
Forming impressions	Anxiety/ Well-being
Interprof.corroboration	about child's behaviour
Dentist	adjusting to diagnosis
Vision	Family History/ Trait
Audiology	Both sides of family
Reliability of testing	
Requires repeats	
ENT input	
Medical/ Paediatrician	
As appt: direct recourse for parent	
PreAssmnt Centre referral	
Questioning input by others	
Health issues	
Dietary	
Impacted on child	
As 'rubber stamp'	
Direct contact - Work with Family	
Indirect contact - Intervention	
Rumour/ Hearsay	
From parent:	
Vineland	
Verbal/ spontaneous	
Developmental History Qs	
Sensory Profile Qs	
Bailey's adaptive Qs	
Observation Child's Behaviour	
In Centre	
Coffee mornings	
Play based assessment	
with Mum	
using Bailey's	
using ADOS	
Liaison with parents	
give info/involve in assmnt process	
Importance of the tool	
Constructs about ADOS	
Has to be Managed/ Staged	
Impact of avlble rm	
expected characteristics of child's engagement	

Involvement of other professionals	can ignore
Involvement of Centre Professionals	Response to books
Reviewing child progress	Pretend play
Experiential feedback	Jigsaw/ Construction toys
Information from Referrers	Inappropriate
Alerting/ caution	not integrated
'As If' Diagnosing	inconsistent responses
Factual	child demeanour
Setting	Not big/social smile
No setting	Smile, but not with eye contact
Child position	Worried/ looking anxious
Child's Age	If adults' not responding
Family living details	Serious
Parent Intervention/ Engagement	Confused by play demands
Attendance on Course	Facial expression
Understanding of Course	unresponsive
Compared with other parents	Liable to be cross
Attributes of Child	directing/moving to adults
Mitigating factors	making random approaches
Social factors	Needs adults to engage
Actions suit personal preferences	to play
Actions follow the obs.context	prefers adults
Time req'd to settle	to have next to her
Unique:	Child's poor grammar
Not seen before	Presents with ASD
Not as extreme a case	Difficult to understand
Observed (Centre profs)	not making sense
Prof.concerning view	Language difficulties
Physical aspects	Noise, not language
Mannerisms	Alot of talk, not socially engaged
Uses foot not hands	Delayed/ very little
Backing into spaces	needs gesture to explain personal exp.
Safety retreat	limited in scope
not looking properly	Lack of fluency
stumbling	Prof.positive view
Not noticing/ remembering	Unexpected abilities
feeling vulnerable	Conceptual understanding
Repeated asking/ behaviours	An able child
appealing to both adults	Shows anticipation
emotional extremes	Looking at objects (in hands)
eye contact/gaze&gesture not integrated	Understands cause/effect
Not looking at adult	A good response
fixed grin quality	Not anxious looking - unphased/ relaxed
Staring from lack of understanding	Social interaction
only when wants s'thing from adult	Response to pretend play
Passive	Response to Peepo
Unusual quality	laugh
Learnt phrases	Smile
Odd phrases	Response to other children
Out of the blue	not aggressive
Aware of different noises	gentle
interruptive effect	Accepts/ takes from adult
Not following adult expectation	Responds to adult initiative
Not creative	No mannerisms/traits
of conversation	habit not seen as over the top
Doesn't request	Gives profs eyecontact
No response to name	Happy to engage
Not even for Mum	Enjoying self
Not taking/building on opportunity	responds to play opportunity
Limited/No interest	Likes mark-making
To snack/ biscuit	Has experienced before
No choice-making	Follows adult model
Turning/walking away	Likes balloon
Holding/ not playing	+ sound
Placing/ not playing	Likes bubbles!
Turning/ not playing	Smiles/ laughs
Interest in other children	A 'real' laugh

Child initiating/leading	Make systematic comparisons
not passive	Alongside expr'tial knowledge'normal' chDev
Climbs to reach	Assimilate information
Goes towards own interest	Using Parent Information
involving adults	Use of non-information
Looks up for more	Surmising what it's like
likes sharing play	Corroborating parent view
Shows obj to adult	Jusifying own position
to indicate more	Judging risk
As comfort object	Discussion post ADOS assmnt
uses gesture	Chronological order
when hasn't the language	Describing/clarifying events
to be understood	teases out understanding
uses pointing/eyegaze	checking veracity of claims
to get what wants	Description recorded
uses asking	Satisfaction
Uses language/talk	Applying criteria/ information from ADOS
Uses echoing	Inferring the meaning
echoing to understand	Adapting to limited options
Child tries hard	Not surprising
Parent-Child interaction	For assmnt purposes
Secure/close with Mum	Fearful for toy equipment
Dependent on Mum	Time required
Parental demeanour	Hard work for adult
following professionals guidance	Difficult to match
able to relax	Ref/linked to obs/knowledge of child
As reported to profs	Asking/offering to give viewpoint
Reported by Parent	Checking for mutual view for scores
Concerning	Factual judgement
Wanting to know if ASD/ADHD	Qualitative (feeling) judgement
Emotions	Using benevolence
Sociality	Relating to previous assmnt experiences
Involving inflex/unusual play/ lmtds	Reaching Decision
Own world view	Overall picture
Involving Development	Suggestive of ASD
regression	Scoring ADOS
Getting worse	Straightforward
Involving care/routines	Categorising scores
provokes parent anxiety	Generates actions based on needs
Stories compare/contrast siblings	Predicting the scores
Siblings get on	Meets ADOS
Not concerning	Checking for mutual perspectives
Accepts parental care/routines	Having evidence-trail
Positive reports	note-taking
Dev milestones ok	writing what is observed
Concerns	Records of Mum reports
Difficulty with routines	Checking records in place
Sociability	Initial formulations
Emotional expression	Nature of difficulty
High repetitious/rigid behaviours	Have to be fair
Speech/Language/Communication	Working Diagnosis
Medical difficulties	Changeable
Impact for child	removable
Sensory issues	presentation requires same treatment
Lick/Smell/Touch	Presentation predicts condition for diagnosis
Contradictory	Review
Action not as it appears	Interprofessional f/up
Missed +assmnt opportunity	When child attends setting
Different professional view	Full Diagnosis
Unmoved	
Information conflicts with reports	
Contrasts with Mum information	
Justifying contradiction	
Factual	
Using ICD10 diagnostic criteria	
Decision child does not meet ICD10 criteria	
Decision child meets ICD10 criteria	

Response to Safeguarding concerns
 Funded nursery place
Organising parent/child attendance
Direct as behaviour modification
 Waiting list for needs-based intervention
 with parent/child
 Parent inconsistent attendance
Giving parental feedback
 Signposting to support
 Child likely to have ASD
 Meets ADOS cut-off
 As end to process
 Write report
Making links between profs
Signposting - additional prof.view
 SISS input
 Waiting list
 GP
 Referral to Paed
 OT referral
 SaLT input
 referral to SaLT
Checking

Professional Dialogue

Helping out
Humoured
Praise/ approval
Excitement, high relevance
 Confusion
Completion
Group punctuated
Providing/ clarifying justification
Thinking out loud
Promoting autonomy
 Self promotion
Expressing satisfaction as conformity
Exhortation to use their voice
Following... agreement
 Echoing
 as reflective
 Power differences (power differential)
Polite framing
 expressing gratitude
Contentment
Checking out

Blinkered
 Interpretation fits own perspective
In-filling - supplying word
Amused
Seeing the positives
Preoccupied- not giving full attn.
Embarrassment/ cover-up
Persuasive
Amazement
Guessing
Neutrality
Prompting
 Following me?
Listening
 New information
Doubtful
Suspended - stopping/unfinished-
 Querying
 Realising
 Recalling
 Blustering
Benevolent
Condescending
Subliminal reinforcement
Leaving suspended (to think more about)
Readjusting
Agreement
 With encouragement/enthusiasm
 Adds weight/ encourages
 Listening/learning
Thinking, non-committal
Attending to
 Curious
Heightened interest
Questioning tone
 Cautious
Acceptance
 Resigned
 As usual
 Acquiescent
 Acceptance with alacrity
 Accepting to pave way to bring up own priority
Personal/ Influential perspective
 Making assumption
Moving on
 Not really listening to each other
Keeping the peace
 Appeasing
 Soothing
Breaking Tension
 Praise/ building confidence
 Providing/ finding humour
 At expense of colleague
Little voice/ tailing off (feeling small)
 Soto voce interruption
Directing/ Instructing
Correction
Justifying (position)
 Giving explanation
 On the Spot
Contemplative
Cut off-
Confirming/ Unison response
Diffusing/ covering up sharpness

Irritation/ dislike
Overlooking
 Disbelief
 Unanswered
 Ignoring and continuing...
 Talking over
 Interruption
Placatory
 & not really listening
Validating
Confirming Self Viewpoint
 Reaffirming
 Persistence (to have say)
 Maintaining own agenda
 Superiority confirmation

7.4.2. Code Verification Sampling

01:35 (zzz)(.) saw him(.) a bit agitated and [er̄ er̄]
 01:39 (www)[yeah] mm hm and then he wanted that[comfort from her]
 01:40 (zzz)[yeah yeah]
 01:42 (vvv) hm̄
 01:44 (zzz)so em I dunno that now ha ha ha
 01:45 (vvv) ha ha ha (...)
 01:46 (www)but what he did do was ve:ry snuggly with her
 01:48 (zzz)[yeah]
 01:48 (www)[but] wh̄ile he was snuggly with her= he w̄as actually giving me eȳe contact
 01:53 (zzz)he was [an I couldn't see]
 01:53 (vvv) yea:: yea::
 01:54 (www)yeāh reā::lly w̄ere s̄urpr̄ised
 01:55 (zzz)its incredible.
 01:55 (vvv) he di- he di-
 01:56 (www)yeāh it it he di- which wa- was a hūge surprise
 01:59 (zzz)[yeah]
 01:59 (www)[yeah]
 01:59 (zzz)because he doesn't
 02:00 (www)ye- no- so maybe that's something an area that he's improv̄ing on- anywa-
 02:04 (zzz)could b̄e(.) yeah
 02:05 (www) I was (...) I wasn't expecting him to: but he did actually give ey- an he did used to- he gave a very sort of quiet little smile-
 02:11 (vvv) mmm yeah ye:s
 02:12 (zzz)you kept saying that's a nice[smile]
 02:13 (vvv) [ye:s]
 02:15 (www)[little] quiet- it wasn't a big-
 02:16 (zzz)yeah
 02:17 (www)it wasn't a social smile
 02:18 (zzz)no
 02:19 (www)but it was a quiet I'm contented here(.)
 02:20 (vvv) mm
 02:21 (zzz)yeah
 02:22 (www)I- you could see that he was quite [secu:re]
 02:23 (zzz)[yeah]
 02:24 (www)next to his mu:m(.) he wasn' too phased about being in [the]
 02:27 (zzz)[no]
 02:27 (www)new environment
 02:28 (zzz)no
 02:29 (www)erm an and he was (.) quite relaxed really .hh and he di:d wa::nt(.) me to stroke his foot [when I moved my hand]
 02:34 (zzz)yeah [I could see he was putting it back]
 (www)[his foot yeah] so that was almost like a little interaction going

*Catal is
restless for
Catal's assed*

*Dispute here - disagreement
over quality of social smile -
Catal here*

*lots of information to process - would the focus benefit
from being narrowed?*

04:30	.h if we look at point 3 he meets nearly everything there we see quite a few restricted repetitive stereotype patterns of behaviour .h he met 3 there which was the preoccupation restricted play he's very interested in Thomas the tank engine .hh he's adherence to non-functioning routine and we do see some hand flapping
04:53	.hh so using ICD 10 criteria looking at information from all our sor- sources he (..) doesn't meet the total of 6 he meets 5
05:04	.h if we look at the cut off he doesn't quite meet cut off
05:07	.h he got 6 and cut off is 7 so what we've talked about with parents is that his presentation is one of probable emerging pattern of autism but he <u>is</u> only 2 (.) years of age and only just 2 years of age he's very <u>young</u> <i>oscillation</i>
05:23	.hh parents are seeing lots of difficulties at home nursery are <u>not</u> seeing the same demonstration of difficulties in nursery .h don't think it's fair to absolutely rule autism out the same point we cannot give a diagnosis because he does not meet ICD 10 classification
05:37	Therefore we've put him on review and we'll see him again in a years time .hh in the meantime we've suggested that people use the strategies that we use with people with autism
05:47	.hh we've signposted mum to all the autism support and given a working diagnosis of autism we've explained to mum that this diagnosis can change it can be wi- withdrawn or it can be erm going on to erm confirm the diagnosis
06:00	That is a summary of involvement with CH02 to date. He's now had so he won't be seen at the (name) centre for another year's time
01:10	Bye bye

*oscillation throughout between
the drive to diagnose & more
cautious approach*

Sample copies (above) of colleague and professional checking to code description, as informed the analyses.

Tables summarising relevant checking (comments &/or suggestions) as occurred from presenting anonymised sets of transcripts, with their uses then shown toward the analyses.

<u>Data source & Text sample</u> [grey fonts]	<u>Provided comment or Checking term</u>	<u>Relevant developed code label, used in the analysis</u>
CHR02\02_PostAssmnt Summary Lines 3-38	Oscillation throughout between the drive to diagnose & more cautious approach	<i>Oscillating in judgements of child capabilities</i> [O]
Working through that criteria Probably one clearly meets and one th- to observe	Hunt for pathology/ Seeking pathology Intent to diagnose? Conflict? ' <u>huge</u> '? (given emphasis); referrals	<i>Cross-refing observation to medical criteria/ descriptors</i> [F3] <i>Strengthening position through overstatements (ECFs)</i> [O]
Systematically Standardised assessments Produced a written observation;	Following process. Justifying the evidence; Evidence? Gathering evidence	<i>Gathering in markers/descriptors of child ability</i> [F3] <i>Ensuring decision evidence (notes) as used in assessments</i> [O] <i>Using information from other professionals influentially</i> [O]

<p>look through diagnostic criteria an see whether he meets that Working through that criteria; phone calls...</p> <p>Is only 2 years of age so as with lots of 2 year olds Mum does report ... things like</p> <p>Lack of modulation</p> <p>We've put him on review</p>	<p>Deliberating weighing up evidence.</p> <p>Communication by telephone</p> <p>Taking up a developmental position</p> <p>Mum's views</p> <p>Medical terminology</p> <p>Caution; 'watchful waiting'</p>	<p><i>Taking a developmental , benevolent position</i> [O]</p> <p><i>Using information from mother reportage</i> [O]</p> <p><i>Putting diagnosis on hold: 'watchful waiting'</i> [O]</p> <p><i>Looking for symptoms/ pathology</i> [O]</p>
<p>Did show his book to parents</p> <p>Going through the file</p> <p>He's happy alongside his peers</p>	<p>Noticing positives</p> <p>Hunting for pathology Discussing process</p> <p>Taking a developmental view</p>	

DATA CHECKING TO INFORM ANALYSES: CHR02.

<u>Data source & Text sample</u> [grey fonts]	<u>Provided comment or Checking term</u>	<u>Developed code label</u>
CHR05\05_PostADOS Lines 4-79	Cotopy: controlling, steering, persuasion, influence	<i>Individual's influential dialogic contributions</i> [F1]
but it was a quiet I'm contented here(.)	Hypothesis, clarify?	<i>Seeing child responding +ve, affirms their prof. position</i> [O]
Yeah yeah Mm mm (.)	Dialogue on the system Influence & persuasion Interpretation Seem to acquiesce lazily to asserts control all the way through & influences decision-making	<i>Comfortable agreement/ echoing</i> [O] <i>Having the final say</i> [O]
So if we- I was pleased with how the appointment went	Professional's interpretation & assessment Controlling – a side category?	<i>Applying ADOS assessment processes to child in centre</i> [F3]
She got down to his level nicely	How is professional influence and persuasion managed?	<i>Taking lead in assessments & decisions as keyworker</i> [F2]
Nice to hear that we've seen him on a good	How is dispute of disagreement managed?	<i>Conflicting over interpretation of child behaviour/needs</i> [O]
I don't think he would]	Dispute.	<i>Leaving it suspended</i> [O]

<p>yeah I think he would have done</p> <p>Bu- when th- when they arrived; I though- now now I sa-saw that differently He was actually giving me eye contact... an I couldn't see</p>	<p>Lots of information to process – would the focus benefit from being covered?</p>	<p><i>Disbelieving alternatives</i> [O] Focus on system processes used in analysis</p>
--	---	--

DATA CHECKING TO INFORM ANALYSES: CHR05.

<p>Data source & Text sample [grey fonts]</p>	<p>Provided comment or Checking term</p>	<p>Developed code label (<i>italics</i>) Analysis contribution</p>
<p>CHR04\04_Panel_1 Lines 4-76 Done (2) <u>Sigh</u></p> <p>Next one</p> <p><i>(loud taps of computer mouse)</i></p> <p>Whe- where do they live?</p>	<p>Actions; silences? Impacts?</p> <p>Systems.</p> <p>Sound impacts?</p> <p>Stutters?</p> <p>Coding for emotions: envy, anxiety etc Transference;</p> <p>Schein:Task & Maintenance function?</p> <p>DA?; Foucauldian power? (as more appropriate methodology?)</p>	<p><i>Significant sounds</i> [O]</p> <p><i>Talk patterns</i> [T]</p> <p><i>Punctuating talk</i> [T]</p> <p>Focus on language exchanges in the analysis</p> <p>Primary task functions (Zagier-Roberts)</p> <p>CGT used for processes & language attributes; (considered non-judgemental method whereby findings grounded in what was heard actually taking place)</p>
<p>Lines 15 - 27</p>	<p>Codings for group process Theory before → GT?</p>	<p><i>Unfinishing phrases-comfortable understanding each other</i> [O]</p>

DATA CHECKING TO INFORM ANALYSES: CHR04.

<u>Data source & Text sample</u> [grey fonts]	<u>Provided comment or Checking term</u>	<u>Developed code label (<i>italics</i>) Analysis contribution</u>
<p>CHR03\03_PostADOS Lines 3-70</p> <p>Some some things... but she is using atleast 2 or 3 words together. Some of her grammar is completely out of Oh her grammar was mm yep yep</p> <p>she noticed the lawn mower outside... Yeah]</p>	<p>Groups' process – very detailed</p> <p>Formal v informal, to methods (ADOS/Observation) and language</p> <p>Listing symptoms shapes the process</p> <p>Talking in code; shared assumptions</p> <p>Real assessment data missing – no sense of the child</p> <p>Decision-making is content-free</p>	<p>Analysis focus on System processes & language attributes</p> <p><i>Suspending/leaving-out descriptors of child's skills</i> [O]</p> <p><i>Counterbalancing +ve abilities, with -ve abilities</i>[O]</p> <p><i>Passive acceptance</i> [O]</p> <p><i>Comfortable agreement/ echoing</i> [O]</p> <p><i>Not seeing things from child's perspective</i> [O]</p>

DATA CHECKING TO INFORM ANALYSES: CHR03.

7.4.3. Audit Trail and Time in the Field

Timeline showing the iterative cycle of data collection and coding up to the point of theoretical sufficiency.

Key: Pre: Pre-assessment discussion Post: Post assessment discussion
 P/S: Post assessment summary
 Add: Additional Panel meeting
 VN8500.: Captured recording
 VN8500.: Denotes end of phase
 nd: No data captured

	Panel1	Panel2	Add.	Pre.	Post.	P/S.
October	11/YH/0341: NHS research ethics approval					
December/January	Presentation of study detail to Professionals					
April	First consents received					
April	CHR01: nd	May nd		August nd	August nd	
	CHR02: VN850026					
	CHR03: nd					
May	CHR03:	VN850028				
July	CHR02:	VN850030				
	CHR03:		VN850031			
	CHR04: VN850029	VN850031				
	CHR05: VN850029					
August	CHR06: VN850032					
September	CHR05:	nd				
October	CHR03:			nd	VN850038-39	
	CHR06:	VN850035				
November	CHR02:			nd	nd	VN850044
	CHR05:			VN850040_1		
December	CHR04:			VN850045-46	VN850047	
January	CHR06:		VN850048			
February	CHR05:			VN850049	VN850050	
May	CHR06:			VN850052		
July	CHR06:				VN850053	
December	CHR02:					VN850054
February	11/YH/0341: NHS end of study declaration					

7.4.4. Reflexive Notes

Diary

First entry to Centre - Summer meetings (July), notes from discussions with Clinical Manager & EP

Manager spoke of the role of EP: previous EP did not effect change. EP is Specialist Clinician, Team Lead (Under-6s). New EP engaged in service development work... and evolution of a model.

Both Manager & EP speak of sense that they would want this captured in the research process – a discussion of difficulties with change to new form of practice. Want to ‘tell their story’; Refer to a change in view for needs based assessment over time.

EP & I express view to manager that the difference in perspective, i.e. the EPs, would become evident in the transcripts.

December.

Pre-engagement sessions [4 events]

1. Observation of play assessment. Present: EP FamCo (Keyworker) Girl (4-years) Mother Grandmother

FamCo plays alongside girl. Emphasis is on engaging in reciprocal play, 1:1

EP speaks with Gran & Mother; explains to them what we mean by ASD – gives explanation of triad of impairment.

EP goes to to play with girl – but she’s not having it (is EP comfortable? at play?)

EP & FamCo – complete ADOS together, after mother/Grandmother/girl leave. Score it up & indicate = cut off for diagnosis of ASD. EP expresses that even though ADOS is an indicator, would need more info. EP is not sure about mother’s diagnosis...? Is FamCo happy with this outcome? Does she think EP ought to be going ahead with diagnosis, i.e. as ADOS is showing it up?

My view – noticing the emphasis on ADOS? Seem to have missed aspects of the little girl’s interactions with Mother/ Grandmother is there reliance on view from a ‘clinical’ appointment?

Ref made to concerns (& EP’s too) over (name) diagnosis for Mother, how & where received – EP speaking of disempowering effects on her ability to ‘mother’/ ‘parent’.

2. Panel.1 EP, ClinicalMngr, TraineeClinPsych, SocialWorker, EYSISS (stand-in).

Seating positions. EP side on/ facing computer whilst other attendees face each other around table and focus on referral forms.

3. Panel.2 EP, ClinicalMngr, (SocialWorker- absent), EYSISS.

Seating dynamics still prevalent. SWr absent (snow day) – effects of present/absent professionals?

Considerations – i) EP ‘immersed’ with medical model view – day in, day out in that context. Hard to be a lone voice? Will I get the EPs view representative of assessment over time in different contexts, in the

assessment model used by professionals at this centre? ii) distance of medics. Paediatricians 'strong, distant voice' – will they collaborate in meetings? Be available? Share in needs-based assessment views.

EP view has been the importance of systems perspective/ approach. All about the systems, the processes.

Perspective given during Supervision – will need to sort if this Centre can meet what wanted from Qs. Have to decide. Through questioning, EPs perspective is different to others. Has she been able to retain her distinctive role when working day-in, day-out within a medical model framework?

*** gap ***

March (after REC consents received)

Notes following discussion:

EP: not every child has exactly the same – works based on need & rationalisation of resources. Protocols to fit needs. 'we follow guidelines'.

3-way group?

Group processes in here & now of meetings

Processes?

Group processes - aspect of belonging to this assessment team (hidden influences?)

Me: Thinking of research Qs. Thinking about assessment and intervention over time.

EP: ...at least 3-months. Confident that making right assessment decisions (said more than once) Following the NICE guidelines – 'its' all there'.

April

Discussion with EP & points made:

Panel cancelled; all paperwork (5 or 6) put through to Initial home visit. If education not there, it goes to pot; i.e. Eds are off in school hols period.

Eg case leading to diagnosis over 3-month period. Diag. conversations: EP + Tchr + parents (Mother & Father). Tchr doing fortnightly visits over 3-month period.

Indicates staff capacity issues x3 fte for all children.

Hold a wide referral brief. Significant difficulties in 2 or more areas of development, on daily basis (review of referral form).

"what works for which families in difficult circumstances".

How stressed/ anxious (level of parent anxiety)

Level of (child) aggression.

"stressful; time; inappropriate at time".

Fragmented discussion expected*: researcher invitation to observe

Won't get the breadth of work in 4 cases... processes similar & how pros work together. Reviewing of evidence & eliminating difference of opinion

Re parents: where they are with us on the work; starts from the initial visit & how will pan out;

Will be genuine partnership, or resistance.

May

Response to EP email re.difficulty obtaining consents & suggestion to move research to Over-6 team:

- difficult to change age-range; consent specified for 0-6yrs, where EP practitioner involved (EP input is just 0-6s, not Over-6s). Therefore would have to adjust for REC practices – added difficulty
- Researcher's resolution: to produce 'script' to use routinely with all parents, alongside Centre's own routine p/wk.

- Researcher to go through wording with Profs, (EP / SLT) as required...
 - Not a problem to wait, but if all new referrals are told about study; Researcher can be available to speak with parents? At visit? By telephone? **(Manager overriding latter 2 suggestions; Researcher signposted to meet with M/ FamCo/ EYPrac ('makes sense, as they're the ones who carry out Initial Visits'))**
 - Hold in mind the +ve: have received one consent, which the Centre felt was one not to pursue.
4. Observation of MDT discussion: (Subject = Male; Yr-1 child).
- Introductions; purpose of meeting; EP – leading?
 - Making ref to the date since referral.
 - Looking to summarise case; check with colleagues if need to correct/ interject
 - Four profs – SISS/ OT/ EP/ ClinP (trainee)/ one missing (SaLT)
 - EP: open Qs for corroboration to SISS: response=agreement
 - Purpose: to look at each profs perspective of development. Refer to U6 team assessment summary & diagnostic review
 - EP: draws map of individuals involved, incl. child + parents. Confirmation of range of profs involved. Paed referral changed to July.
 - July last year – school Q'ing if ASD diagnosis
 - OT: reads aloud summative assessment report from school; Ref to small stature child – smallest in class; Qs "Is he prem?" Yes, at 36-weeks
 - SISS: 1st obs, March a year ago: bouncy, bubbly, bright 'covering up difficulties'. Masking that struggles to understand what said to him
2nd obs, later: facial features changed dramatically: recognition as Williams Syndrome?
 - Leads to recommendation to book appt to be s/b 'consultant community paediatrician'
 - Parents didn't make 1st appointment (DNA).

During meeting, prof referred to:

OT: Movement ABC re co-ordination/balance; neurological signs discussed, 'jerky mannerisms' reported by school. Reference to 'cut-off' for dyspraxia. Child improved with practice & was keen to keep trying.

EP: Cognitive profile; did not report scores, said 'not severe but impactful'. information from school: how using language in the class: from Vineland. Expressive vocab. 95%, but naming – not using functionally; Early hearing difficulties - disordered language profile.

Qs re attainments – Maths, P7, Reading P5.

SISS: Visual perceptual skills: referral to standardised assessment of visual skills.

Qs EP view; child becoming wary after seeing an awful lot of people

Summary: EP 'I'm happy' – echoed by others. Joint view; no ASD diagnosis 'won't go near that'.

(Why was this meeting described it would be a 'fragmented meeting'?)

June
Msg from EP: **3 consents**
received!

- Transcription thoughts

<u>July</u>	Thinking about feedback from the Centre - that overwhelmed with high number referrals. Is this as a result that the service is open/ available?? Reference to 'cross border issues' : in-group / out-group effects? Centre with 'power' of effect - influences children to be seen, professionals putting on waiting lists (Selfe...?)
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	Length of time - number of cases. Less time spent towards latter cases ?? Primacy / recency effects???
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	No background discussion of referral details. No record of decision at panel 1. Re reading transcript. Nothing there. Fits readings from Aquarone, Alvarez, Tustin etc, where projections from child(?) stifle, cause flat response , in the adults?
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<u>Sep/Oct</u>	Numbers of children! Flat responses when case discussed (numbers already gone through) ... (ref to heat "it's so hot in here. Really stuffy") EP: ref to "little one", age issues? Overridden by less experienced prof: saying it's "early intervention".
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'next' 'next' (conveyor belt)

October

Call to EP: Researcher – coming through re numbers in Panel meetings

EP: been speaking with colleagues in neighbouring LA (where used to work); approx. 40/year; here, we're doing 120/year. They didn't know what ADOS is (diagnostic tool) – how could they not, in own (EP 's) view.

Invitation to observe professional discussion re clinical picture from ADOS & make process notes**

Again – telling me it's a good process, 'robust' – saying it has to be, it's complicated.

Is pressure of numbers causing 'quick-fire' decisions. Recommendations (followed) from NICE??

Also - EP: recounted experience, when once (when?) didn't diagnose – it led to difficulty with parents... including legal challenge (reflecting...) **Has this created pressures...?**

	Two hours in (longest so far) Lots of reference to procedural stuff - explaining processes to internee (new?). Check. Had enough? Laughter - hysteria type... Making me laugh: seem to be losing children in the system. IT skills?
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	Consistency of decisions by different professionals; So much shuffling of papers!!! SLT always loud. Position by microphone. Level of importance...? It is a lot of children and it's getting bigger every day EP 's voice always v quiet & in the background... EP 's concerns re very young age - not heard/ being listened to? Why not? What will happen about this? So many pauses; ponderous exchanges. Stifled assessment discussions? Stated aims v actual aims (needs assessment & intervention or to diagnosis/ not diagnose) Professionals' attitudes? 'Gatekeeper' role for diagnosis; effect therefore, for that
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	individual within the group?
	Remember EP referring to fact that decisions can be inconsistent. Why at one panel a child goes through, but another wouldn't. Qs if any difference in the detail...? Just realised - that TCHR_2 has not contributed all discussion. 3-way effect acts to 'exclude'. May be a reason to be assertive, when there's more of an opportunity (i.e. when M not present?) No – wrong person!
	SLT dominates discussion. Power of a manager? SISS staff appear 'in awe'? TCHR_3 (of SISS) wanting to learn of process...? TCHR's - actually teachers? Early Years trained professionals? Level of qualifications...? EP - trying to maintain threads to discussion. On a tangent/ limb to the dyad (M + SLT) ?

Observation of dyad discussion, post-ADOS** o/a already commenced prof discussion. (6-mins in)

Broke off to meet n greet me - long explanation of what they were doing re ADOS discussion

Passivity of EYPrac in dyad discussion - a lot of mmm's and yeah's...

EP doing all talking of analysis

EYPrac: hasn't talked about/used any detail of the home visit/made links to ADOS assmnt? at all...?

Child attends clinic at convenience of adults... not a natural context for child...

Not much mention of mum...?

Stronger influence of EP - doesn't like it when 'directed' (same with Clin Mngr (SLT)?)

- Close scrutiny of ADOS criteria against observation material.
- 'when stuck aswell' – hand/ arm shaking gesture by EYprac
- 'wanting Mum at table next to her' : 4-yr old girl in strange play environment – large room, few adults, most strangers). Consideration of child's perspective here?

	<p>Later: long explanation from EP re Organisational position & difficulties i.e. use of data? (now) 180/190 in U6s and in (name)LA 30-40/year (Conflation effects?)</p> <p>Refer to management responsibility – (not holding) none of the big picture. Constant misinterpretation, Inaccurate data. ClinP trainee, looking at U6 spreadsheet to get fit for Audit. Can't not impact.</p> <p>Again - saying sure that what doing is robust saying that absolutely sure meets NICE clinical governance. Look at quality, achieve/ don't achieve.</p> <p>Have own data – U6 component</p> <p>My influence on EP? ... now doing own Doctorate and as I'm leaving, reflected on the tension of personal position: social model v clinical/medical model. Has real difficulties - harder and harder - to keep separate?</p> <p>Is my walking into Centre here, affecting EP, self-reflection of position/ role?</p>
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<u>November</u>	<p>Transcription ideas - within a triad - feels as if 2 are communicating around the 3rd</p> <p>Is it worth laying out transcription to reflect individualities and their 'isolated' interactions?</p> <p>Eg</p> <table style="border: none;"> <tr> <td style="padding-right: 20px;">Person 1</td> <td style="padding-right: 20px;">Person 2</td> <td>Person 3</td> </tr> <tr> <td>Speaks</td> <td>speaks</td> <td></td> </tr> <tr> <td></td> <td>speaks</td> <td>speaks</td> </tr> <tr> <td>Speaks</td> <td></td> <td>speaks</td> </tr> </table> <p>Rather than lining each person chronologically...</p>	Person 1	Person 2	Person 3	Speaks	speaks			speaks	speaks	Speaks		speaks
Person 1	Person 2	Person 3											
Speaks	speaks												
	speaks	speaks											
Speaks		speaks											

Number of different people - requires organising... confusing me, who's saying what...when...

<u>Abbr.</u>	<u>Role</u>	<u>Prof backgnd</u>		
SLT :	Mngr/ClinLeadMC	(SaLT)	TCHR_1 : ??	TCHR_5 : ??
EP :	U6 Team Lead	(EdPsych)	TCHR_2 : ??	
SWkr :	Children Disability Team	(Soc.Wkr)	TCHR_3 : ??	
M :	Mngr U6 (SISS)	(EYs ??)	TCHR_4 : ??	

	<p>Are they talking themselves into giving a diagnosis? They are seeing the positives - and then not seeing them... The child is being fitted into their professional constructs; the characteristics of the child are fitted into their boxes?</p>
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<u>January</u>	<p>Qing any impact I have of insisting an EP in the MDT set up (what difference would these research findings have with for e.g. (alt. assmnt CC name)? Replicability of findings?</p> <p>Will results reflect group dynamics/ processes as a function of the nature of referee diffs? &/or Org structures and 'afflictions' would affect any team - not necessarily going to be different because of Professional specialisms...?</p> <p>Often same 3 in panels : EP, SLT & M.</p> <p>EP is marginalised?? twice now, over ridden by others (TCHR & SLT) in meeting discussion...?</p>
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My awareness of time? - Long passage of time over which recordings have been made. Could be valuable evidence for Intervention over time... no evidence (yet) of discussions about this/ using this angle on assessment detail...?
Children's lives... ?

EP's described experience of taken to prof. liability hearing, re ASD case...? Impact of this?

Implicit belief/ faith in what they provide...

A case of some missed opportunities e.g. can CHR05 respond to own name
Age of referrals getting younger..?

	<p>Efficiency? Handwriting, rather than dictation?</p> <p>Thoughts of benevolence? Trying to do/ actually doing, a good job, trying to give response to very concerned parents?</p> <p>Length of time ? to go through some cases versus length of time to discuss consented for youngsters...</p> <p>Power struggles?? (EP /SLT) Influence of M? "she's good"</p> <p>Why (name) Centre?</p> <p>Varying the routine - change order ie panel2 before panel1...</p>
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For analysis support at Tavi - remove prof speakers from scripts...? Level of influence to interpretation...?

Seems to be strong(er) influence of TCHRs...? Overriding the EP ...?

Almost like my interview Qs has given EYPrac 'a voice'. Does not feeling they have a voice cause influence to occur more subtly?

April

CHR03 - EP identifying needs based action plan. EYPrac influential in using mm yeah a lot; seems to serve to encourage?

My perspective - attitude of people generally to EPs – resentment, perhaps?

EP is one who can "give a diagnosis" so perhaps viewed a powerful influence by professional background (in this set up...)

TCHRs aspire for that position - perhaps? Therefore use subtle language patterns/dialogue to influence a diagnostic decision?

Are TCHRs less responsive of the organisational requirements to follow through on identified needs...? as they are raised by the EP.

August

I have to hold in mind that it has, at times, been a real effort to maintain drive, to do this analysis.

Being mindful of the transference effects of working with ASD (Aquarone & hopelessness...etc) is helpful to maintain right momentum... same mirroring as in Centre? Reflexive position

Meeting/Qs with Centre Manager

To clarify issues arising following transcription, analysis phase.

- Re research: No concerns being raised by Centre; happy at level of confidentiality.
- No contact rec'd from NHS research consortium...

Referral form

- Re change to: Cases in study on old forms. Changes – extra section ‘sensitivity’ (for parent referrals mainly); Referrer to list allergies/ medicines; Removal of SW service – theirs is for severely disabled children; removal of Part 3, why referring child.

Staffing

- EP takes 4- to 6- years; SpHV takes U4s (**not clarified to me at outset of research ...**)
- Professional roles clarified and Re: Social Workers (absence of...) :
 - Used to commit to Panel; could be up to 3-hours, therefore felt not best use of their time? Opted out.
 - Were needed for to check social care records; ‘invaluable’ for getting this & present to Panel & be involved in discussion
 - Now moved out of Centre teams; have own legal time responses therefore difficulties to work together, ‘barriers’ with their requirements to structure of their Service – taken them in different direction to MA working, *‘more concerned with keeping child safe than assessment over time’*.
- Use of term ‘specialist’: relates to NHS grading; New Graduate (5); Experienced clinician (6), (supervised by Colleague); Specialist role (7), own responsibilities & offer supervision to 5 & 6s.
- EP: parents wrong impression with title, thought was just for education and not a clinical role: introduced title Ch & Ed Psych (‘tells me is entitled to use this title’ tone of voice when says this?); f/t at Centre & funded x1/day/ week for LA EP service - supervision & CPD.
- M : Specialist Teacher. Employed/ managed by LA. ‘sifts’ children too for learning need, but may refer for Child assessment; involved in the full assessment process & work with family as contribution.
- Initial visit: carried out by the most appropriate person; can be either SISS or Centre staff; treated the same.
- FamCo : Centre invented the title;– needed a link role to pull Complex medical needs children all together, but because then with fewer children, became involved in Initial Visits for younger children, or as support for Paed with ADOS as 2nd person (**puzzled by that; Paed’s don’t ‘do’ ADOS?**)
- Qs re- input of OT, Physio, audiology etc, *‘yes, we’re a small team really’*

Centre measures

- Measured on time, not quality; target set by the NHS Trust: 50% to be seen in 18 weeks; clock starts from day received the referral – date stamped & logged onto system. Clock stops at first face-to-face contact i.e. initial visit counts.
- U6 team was within the standard – but since loss of staff now not in standard. SISS picking up some visits, but still a way behind. Red rated – get more attention then; *‘might then listen & give us more staff’*

ADOS

- Training – All team have been trained, including SISS & EYs practitioners - held a complete refresher in last 3-months. Have access to 2 kits & Toddlers kit
 - SISS not formally had training, but have had training through being shown the process.
 - *'Only test in the world that is play-based & standardised'* is a key thing. Strong clinical agreement.
 - Re Scoring: most difficult to score, great deal of interpretation re actions, intentions. Not confident scoring is consistent, as a team. How does child do shared attention etc...

October

Re CHR06- strong character TCHR is not dissuaded by SpHV 'looking for symptoms'. SpHV reassures by saying will check on hearing...

How 'specialists' see effects of hearing difficulties?

November

CHR06: merged with another child. Not realising until recognised gender change (he from she). Was M then F but confused if ref'ing to mother...

No discussion of referrer detail; straight acceptance because of referee?

Inconsequential inputs v influential pondering, which instils into the process.

Significance of (just) 2 figures in assessment decisions?

Describing, not understanding/interpreting child's behaviour.

Reflexivity: EP discourses against labelling/medicalising not equated to actual research within field to relate this discourse to actual evidence.

Second, impromptu meet with Centre Manager.

- In breach of contract because not meeting 18-week targets – impossible to get specialist staff: have lost staff and understaffed
- Clinical Psychs want CAMHS work and speech and language therapists 'don't want to do it'

Perhaps this is an impossible area of work?

7.4.5. Researcher Memo Sampling

Memos

First memos → Fed Code System
 Supported Word finding for analysis.
 ↑ understanding for → Group effects
 narrowing etc.

asking Qs of the data eg Memo 23, Memo 93
 relating "as if", The child eg Memo 31, Memo 130

An "Open Door" Centre towards * Research → Why?
 Memo 242. "abandoned profs" ?
 Memo 258.

years / oh goshes

Prof anxieties
 - Safeguarding
 - evidence / notes
 accessibility for initial visit } - signing
 profs? parent influence (Memo 190)

Individualistic Approaches = Memo 140
 Manager's wife
 Benevolent = Memo 203.

* representative of med. model for 'Rigor'

Conveyor belt effect → Once read out ref from details
 child as trajectory towards medical labelling /
 diagnosis. ??
 (except CHROB: Why?) + Memo 202
 + Memo 213.

Memo 175 Paed about - Isolated profs, doing "crystalline"
 Memo 187 Work

Child's Voice? "Unsafe" Panel System =
 (Cant's term) Memo 191

(Inter-)

Relationship between SLT, Yed + M ??

→ Memo 196 Memo 211 (mirroring)

Is it possible they're reflecting 'wash hands' approach of Paed, in the way manage own work responsibilities

Yed "Yeah's no rush"

* M S'funny I lost him (didn't see) } cause of blips
 * SLT S'Oh ... } in system
 - accountability

Own Roles/functions in group

→ Y Spreadsheet data oversight

Ref. to Memo 250

→ SLT NHTs outcome measures

→ M Mediator / Siss priorities

S'vision ref. to wanting me to use discourses of power.

power of Paed? attention to "lesser" profs; yet they abscond the resp to "make diag"/assess

= use indirect methods

Shadows figure??

= Memo 282

dehumanising = protective function??

isolating work

Look up re. Memo 212

Separate

Kynskir - close down other prof's opps.
 this is style in ADOS assessment.

Race to diagnose = Memo 228

Memo 231 ⇒ "Can't see the wood, for all the trees"
 Memo 237 Syndrome. blinkered in panel
 Memo 281 every child is assessed??

Continuing & limited holistic information

= Why - what happens if goes on longer

NHS = wait times; can't have Ch. in system for too long or becomes clogged & new referrals

back to conveyor belt analogy!

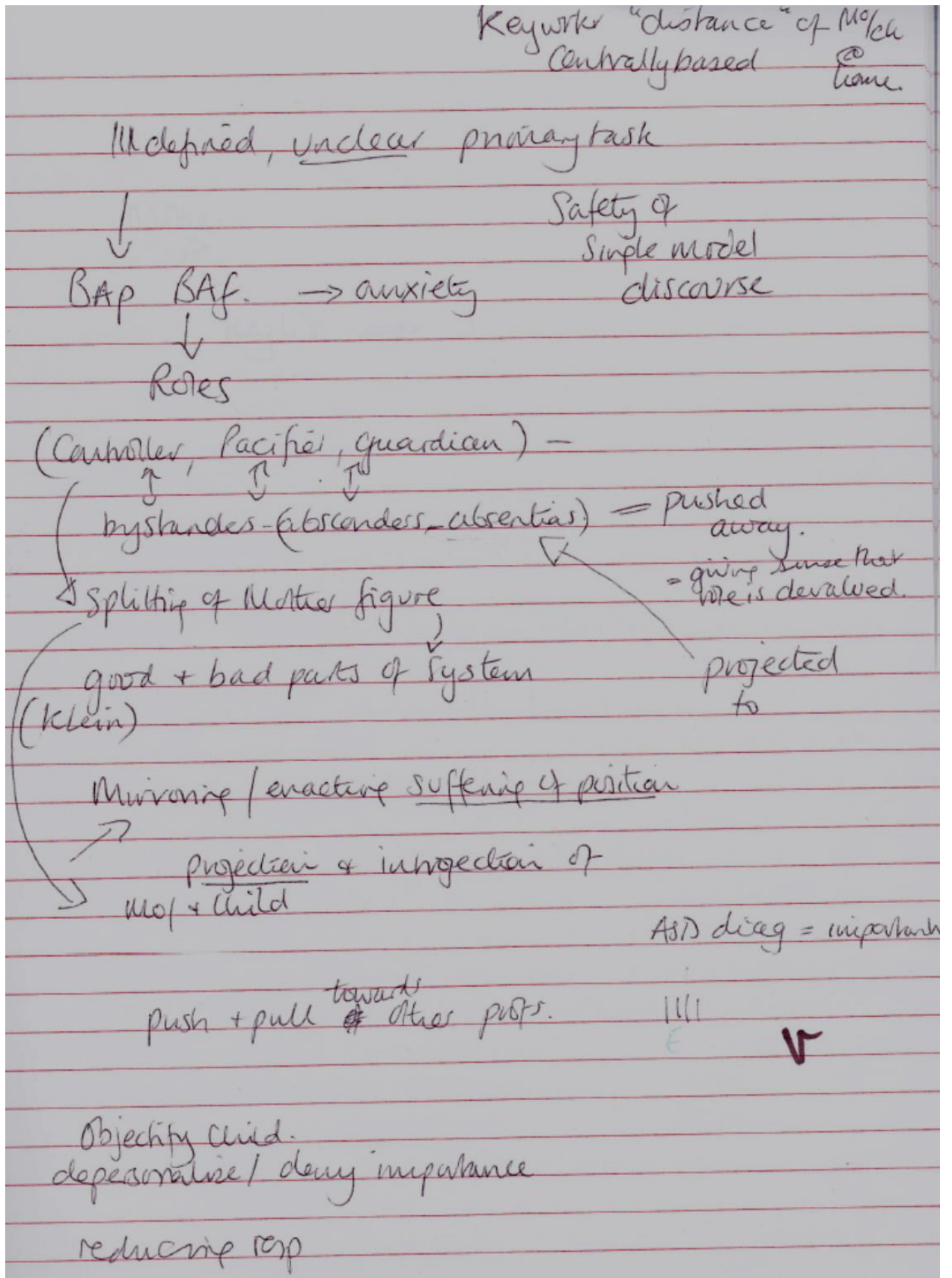
• Memo 251. How prof. actually use the info. they receive

Memo 252: actually a lot of audio is oral report without much quantification; i.e. permission to look in files → results of that.

Memo 296

An abandoned team → no one wants to do this work → not utilizing real strengths of MDT as a unit; pressures to meet deadlines / outcome measures...

7.4.6. Researcher Diagramming



ACTION Referral system^{Pr}

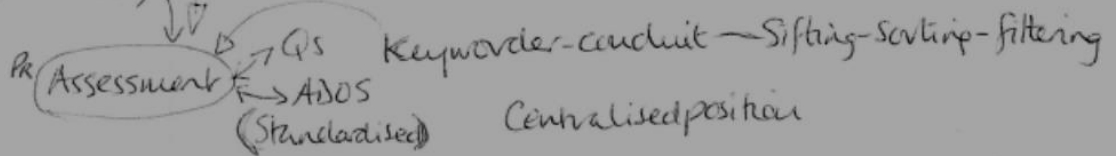
open-door^P conveyor-belt^P clock ticking^P

(evidence-base)^P



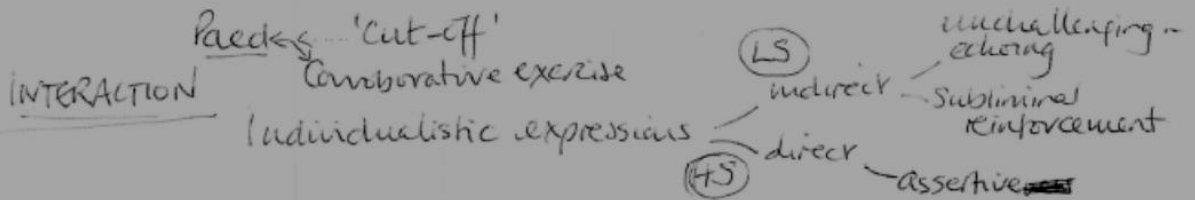
Initial visit^{Pr} → influential recommendations

(Observation)^{Pr}

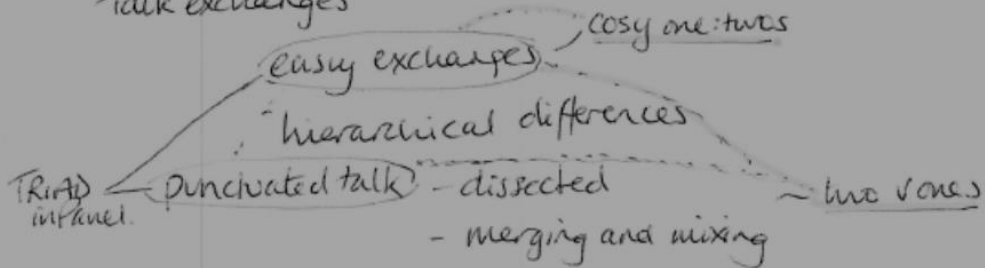


Counterbalancing weighing-up Cross-ref'ing to medical criteria

Interpretive caveats
 qualitative-feeling sense



Talk exchanges

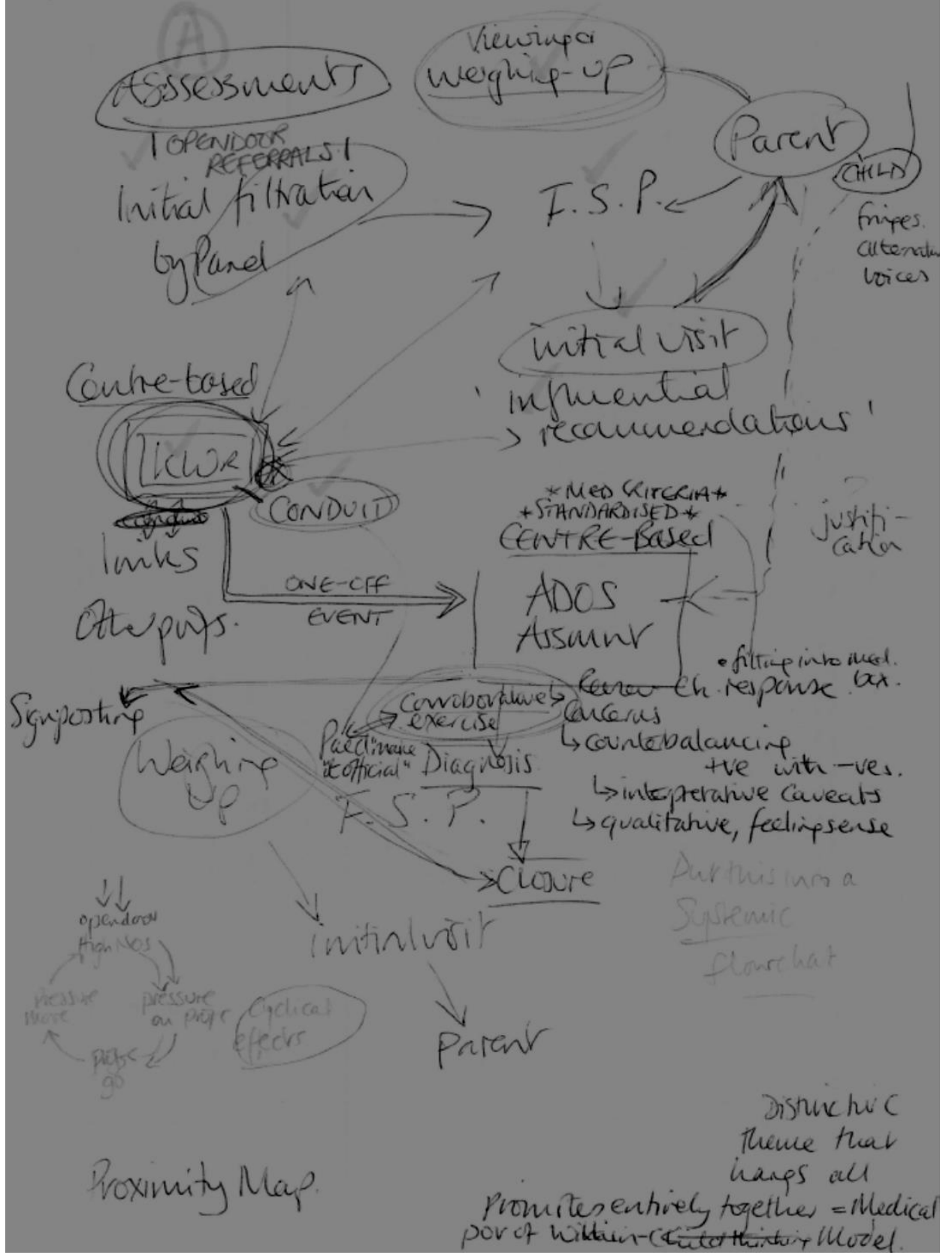


Mirroring — child attributes

nature of work — objectify child
 — shifts, sighs, repetitive

Frictional decision-making — Suspended disbelief, non-negotiable

*Sifting - Sorting - Filtering



7.4.7. Researcher Memos

<u>Event</u>	<u>Line</u>	<u>Numbered memo</u>	<u>Memo content</u>
CHR02	51	Memo 1	Jocular diffusion and laughing at own joke 19/08/2013 23:01:24 Playing out the current 3-way group - TCHR_1 as butt of jokes?
Assmnt_1	92	Memo 1a	possibly too difficult to 'follow through' on other profs services (time delays etc) hence lowered tone of voice and continuing with diagnostic decisions with partial information...?
CHR02	49	Memo 2	'but...' precursor to crossing over 13/08/2013: continuation of cautionary voice - parent attending course may give time for things to get better? reiterates perspective that child is young...
Assmnt_1	21	Memo 2a	justifying to confirm own beliefs of prof. view of poor speech
CHR02	54	Memo 3	Of all the parents (7) on the course this Mum's understanding was the best - so CHR02's concerning attributes can't be to do with Mum?
Assmnt_1	67	Memo 3a	Adults echoing! Reflective of their immediate discussion points
CHR02	62	Memo 4	EP waiting: allows others to finish speaking (patience) then speaks. & 22:47(EP) [Is there any-
CHR02	62	Memo 5	EP keeping focus on the task 19/08/2013 22:43:14 EP specific task, though to keep database updated, so seeking the info needed to do the job...
CHR02	74	Memo 6	Caught out! Now TCHR_1 making potential Freudian slip! Previously not hearing concerns that child very young. Is this a contradiction: Too young for a setting; old enough for diagnosis...?
CHR02	71	Memo 7	Scrolling the database?
CHR02	78	Memo 8	EP is a voice of caution. Listened to?
CHR02	81	Memo 9	Awkward moment. EP is not happy about referral patterns, but is avoiding getting into a clash, so outwardly gives verbal agreement - will perhaps use influence later, with Keyworker?
CHR02	82	Memo 10	SLT using humour to break atmosphere...
CHR02	85	Memo 11	Asking EP, but TCHR_1 giving response
CHR02	19	Memo 12	Be aware, influence of EP saying to me that feels research will throw up aspects to do with personality diffs, rather than prof traits.

CHR02	45	Memo 13	Use of hushed tone - indicates seriousness of mum's position & risk
CHR02	8	Memo 137	EP uses a cautionary voice. Prof perspective highlights awareness of child's age; that too young for diagnostic process? This conflicts with other children, also very young but for whom no expression of concern. Perhaps a form of power structures played out?
CHR02	13	Memo 138	Contrasting researcher view? Why would knowledge obtained through delivery of Programme to parent by EYs worker, be denied as 'working with them'? What does working with the family look like then? Is working with them meaning they're on your caseload - and then what?
CHR02	14	Memo 139	<i>Right</i> is thinking why TCHR_1 can say that 'knows' all this/be certain of CHR02s presentation if not allocated (Does this mean that views of deliverer's of Centre programmes are not valid/recognised?)
CHR02	16	Memo 140	cross purposes?? EP asking whether the child is 'known' to SaLT; TCHR_1 reporting on SISS involvement (particular perspective/ 'world view'?).
CHR02	18	Memo 141	When EP questions, follows response with soothing ok, diffuses any antagonism (why is it like this?) Accepts that TCHR_1 stating no SISS involvement means SLT referrer knows child (does this become a statement of fact by Panel2)
CHR02	19	Memo 142	Contrast with SLT who uses (hollow) laughter to act as diffusor...
CHR02	21	Memo 143	(copy-cat) laugh (after manager's)
CHR02	24	Memo 144	EP cautionary voice again...
CHR02	27	Memo 145	EP persists to have 'voice heard'; finds opportunity to interject again...
CHR02	30	Memo 146	Overlooking an important diagnostic contradiction...?
CHR02	36	Memo 147	SLT & EP: both appear to be thinking about the age & referral info. Decision then seems unanimous, but...? not entirely appropriate to what EP has just questioned; more akin to where SLT & TCHR_1 are going? Repeated audio playbacks & EP's voice is the 'lone' one...
CHR02	37	Memo 148	Decision to accept with doing a home visit is not the same as proceed to full assessment
CHR02	45	Memo 150	mundane talk... relevance to assessment of child needs?
CHR02	9	Memo 151	Vying for influence: interrupting and dismissing (by not attending to it) the content of previous statement re age.

CHR02	32	Memo 152	TCHR_1 uses affirming statements in support of descriptions that fit with (own) initial assessments of CHR02.
CHR02	43	Memo 153	TCHR_1 seems to have the answer for every eventuality...
CHR02	57	Memo 154	Looking for a way this information can be used?
CHR02	64	Memo 155	Training (in, it seems, how to use own position?) - Panel procedures
CHR02	66	Memo 156	Does sound condescending... i.e. we (need) 'use' your feedback as part of our assessment processes... though having the 'real' influence (to "make the diagnosis"). (Will this information be used?)
CHR02	76	Memo 157	Previous comment - gives cue to EP to raise concerns again re age of referrals...
CHR02	80	Memo 158	SLT: 'head in the sands' moment, whilst there's staff conflict...? Does not seem to seek to influence the discussion?
CHR02	31	Memo 159	Reading aloud from referral form - the 'reader' is in stronger, (control) position (it's usually SLT doing it; has been offered to M occasionally...?) Think about: SLT/M relations SLT/EP relations SLT/TCHRs relations Also, when SLT says 'right', 'ok', 'erm' ... a voice of pronouncement?
CHR02	22	Memo 160	Following uncomfortable dialogue, recourse to straight-forward, factual detail - safety zone!
CHR02	28	Memo 161	EP: changes tactic, from just one child's age, as too young, to a huge (extremism to give additional reinforcement of position) number of referrals getting younger!
CHR02	37	Memo 162	Use of 'just' implies choice to 'just' home visit, as opposed to choosing to 'full assess' straight off. However generally, children seem to be going from Panel1 to a home visit, back to Panel2 where the decision is taken then whether to Full Assess, or not? <i>Just</i> - means there is no other alternative? A part of regular routine...
Panel_2	33	Memo 163	Amount of time taken to locate name on database - efficiency?
Panel_2	37	Memo 164	01:25:09 (SLT) panel was 11th [of the 4th reference to panel, as if occurred in current format. No discussion about the nature of panel1: that was one professional who had to make single decisions...
Panel_2	43	Memo 165	Use of term 'specialist'
Panel_2	42	Memo 166	SSP Qs left with parent following home visit. Will this parent understand Qs?
Panel_2	43	Memo 167	01:25:09 (SLT) panel was 11th [of the 4th The offer to do something is interrupted. Appears like Panel2 process is to rubber stamp home visit's result: to full assess for ASD. No actual discussion of home visit details?

Panel_2	46	Memo 168	but (EP) and I are gonna work on thresholds and indicators... Does this mean that therefore there aren't 'thresholds & indicators'?
Panel_2	49	Memo 169	Texting during panel?
Panel_2	60	Memo 170	Brusque/ impatient?
Panel_2	56	Memo 172	Refocusing on the task, after humorous exchange
CHR02	31	Memo 173	Subsequent discussion reflects awareness now knowing this child is recorded... Manager dominates discussion
CHR02	36	Memo 174	EP feels need to provide reason to the manager as to date discrepancy...
CHR02	4	Memo 175	Organisational term: dysphagia ones - the children referred with complex medical needs (Manager says about 30 per year and require a different sort of assessment experience) It seems there is much more of a 'team around the child' approach, due to range of needs. Less a factor for ASD/ADHD children - more dependent on specific needs, e.g. OT or Physio according to specific requirement or mainly SaLT, Paed input, in addition to Centre personnel?
CHR02	8	Memo 176	very little aswell - implies this has already been discussed earlier; rearing again.
CHR02	7	Memo 177	As a parent to a small child
CHR02	17	Memo 178	Us = SISS
CHR02	17	Memo 179	Knowledge limited to personal working level. EP & SLT looking more holistically??
CHR02	15	Memo 180	Finishing off with making influential statement...
CHR02	28	Memo 181	EP is one noticing spreadsheet patterns, but she is the one who always completes spreadsheet, during panels. Possibility to diversify roles??
CHR02	64	Memo 182	my (.) and seeing your writing it put my view is that(.) = SLT perhaps making freudian slip!
CHR02	69	Memo 183	'we': implication that it was a joint decision, between SLT & EP. 'for this one': yet another, part of the regular, routine.
CHR02	32	Memo 184	Recorder effects...
CHR02	44	Memo 185	Clutching at straws...
CHR02	19	Memo 187	In considering the supervisory Qs (during presentation to M5) who is driving the need for diagnosis... Paediatrician with 'power' but 'washing hands' of the process and being called in to 'rubber stamp' the decision made by the centre professional (Keyworker). Links to CHR04.

CHR02	33	Memo 188	"cut off" relates to the threshold for the ADOS. Code 'in-vivo' in regards to the term "cut-off".
CHR02	34	Memo 189	To incorporate that the process of providing diagnosis is to satisfy a parental requirement/ need...
CHR02	35	Memo 190	Does this mean the parents view is the preferred one...?
CHR03	39	Memo 191	No MA panel on that date; single professional went through the relevant referrals for the date, including CHR03. Status is picked up at next Panel as if nothing different. i.e. you might expect professionals to indicate a quick check because the cases were reviewed previously, alone...?
CHR03	47	Memo 192	A lot of the time for this referral, was spent locating/ making use of the recording systems, adding therefore to the pressure of lack of time? An outcome would be to think about the system efficiencies.
CHR03	0	Memo 193	Overall, CHR03 has appeared to progress through x3 panels, with no shared professional discussion of her strengths &/or concerns at each.
CHR03	28	Memo 194	Unwinding... Professionals are aware they're "on the last one" of a list of many. Already starting to fall a little flat...
CHR03	50	Memo 195	Convenience of modern communication: texting (during panel meeting!)
CHR03	55	Memo 196	Manager to Manager - perhaps indicating that SLT has no influence? not SLT's responsibility so makes innocuous quip about it being M's own judgment call. Manager's status differences/similarities, and when working alongside each other?
CHR03	19	Memo 197	SLT not likely to be aware of formats as usually spreadsheet completed by EP
CHR03	39	Memo 198	Child has been awaiting allocation of a Keyworker since April, when accepted at Panel2. Now July... the query from M could well have been initiated because of the length of time of the delay? But SLT, although realising the request would be to know of Keyworker allocation, not alert to the fact of length of time/delay...?
CHR02	20	Memo 199	Munching biscuit - comfortable!
CHR04	10	Memo 200	From exchange, this child is already known to SISS (a visit has been done already, although M can't remember when/ about it). That the referral has come via SISS, and is known to M, therefore can accept straight away? Conflicts with previously voiced concerns about young age (what's the difference between 18-months and 2ys3mths?)
CHR04	32	Memo 201	Each individual's sentence is broken up, punctuated by the next person ** BA gp ** ??
CHR04	3	Memo 202	Panel Functioning? : is it working in terms of being able to by-pass, filter away

			any child that is not likely to meet assessment criteria.
CHR04	8	Memo 203	Passing reading out role to M as child is already known
CHR04	3	Memo 204	10-days ago when M was to provide information; subject to clouding effects of decision making process at previous panel?
CHR04	4	Memo 205	Over 10-day period, SLT has 'forgotten' about previous discussion/decision relating to this child from Panel1. Significance of 'tight' systems for tracking, processing...?
CHR04	15	Memo 206	"[weeks just] tick by" - as a ref to Bion and time in BA groups?
CHR02	11	Memo 207	FamCo is using panel routine to pass on SISS referral form to M, following recent Initial Visit to CHR02. Consideration maybe of the closeness of the Centre personnel with SISS personnel?
CHR04	9	Memo 208	SLT passing it to TCHR_4 - channelling Qs to M & requesting outstanding information. There has already been a delay in response and this latest decision brings a 4th person into the equation
CHR04	62	Memo 209	Would be the opposite? By being new, more noticeable? Why was M looking at the database - is that part of the routine prior to Panel - to go over likely children that are expected to come up?
CHR05	8	Memo 210	Purpose of EP signature?
CHR05	10	Memo 211	The threesome of SLT/ EP/ M seems key. (A triadic relationship.) EP & SLT = friction M = often the appeaser; M & SLT = humoured relationship. EP = often the pragmatic, sobering influence
CHR05	18	Memo 212	Flat toned voice response, is proportional to the descriptor of the child being read aloud. (Reflective effects/ transference of this child's (alleged) difficulties and the cumulative effect of processing children with same/similar difficulties). **REVIEW**
CHR05	29	Memo 213	Speaking of children: depersonalising (processing them through, like on a conveyor belt).
CHR05	46	Memo 214	Implies all that is needed is to summarise those involved and so enable moving on to consider the next child.
CHR05	44	Memo 215	Inter-relationship of the Centre and SISS- including the expectation that SISS will be involved - (they weren't a priority referral by the Paed).
CHR06	8	Memo 216	Real sense of friction when these two are alone...
CHR06	19	Memo 217	Possible that raised levels of GPs writing in is the effect of knowing of the nature of the service offered. Presents as an easy option to signpost the parent and

			(therefore) shift any burden of responsibility away...?
CHR04	3	Memo 218	Realising that this one is not too old, implies many are...
CHR03	135	Memo 219	Feels as if EP is more concerned that they will be able to justify their decision, as if aware of its' weak basis? (recall description of legal effects, too)
CHR03	154	Memo 220	About to give an actual description? but interrupted and unable to finish sentence
CHR03	161	Memo 221	Talking themselves into believing ASD. Are they un/consciously aware of the criteria that score significantly to the final tally?
CHR03	213	Memo 222	Child gives good response to her name call
CHR03	243	Memo 223	EP taking lead role throughout discussion; EYPrac acquiescing frequently: echoing, saying 'yeah' a lot and now even more encouraging...?
CHR03	247	Memo 224	Attitude of adults towards the Rabbit affecting child's response?
CHR03	300	Memo 225	EP: priming for a point of view - but then its actually an opener to give own point of view - doesn't wait to hear a response!
CHR03	386	Memo 226	Back to front... it could be expected for OT and SaLT input to occur alongside/ before an ADOS assessment and for those professionals to contribute towards the gathering of information. Lays open questions as to validity/reliability of an ADOS - child assessed in isolation; the context of what they can/ can't do outside of the specific assessment is overlooked/ not used.
CHR03	361	Memo 227	Overall - a 'low' set of scores, but these 'strengths' don't inform at all to the final equation
CHR05	31	Memo 228	If child was referred at 22-months, family and profs have responded to refer in 6months, approximately, (assuming correct report that 'lost' language at approx 16-months.
CHR06	47	Memo 229	In other words: doesn't have ASD and SpHV picks up on this and is already thinking ahead to organise SaLT input, irrespective of the ADOS assessment.
CHR06	6	Memo 230	Reinforcing own position, from pre-assessment discussion
CHR06	12	Memo 231	This child's not a priority - yet panel/ initial visit information didn't set him apart from the others, particularly?
CHR04	29	Memo 232	Is this totally new information for the paed?? It's a bit tough on the Paed to be expected to confirm a diagnosis with such limited involvement? and only after a précis of the situation?
CHR04	61	Memo 233	Overlooking to relate child's potential experience of modelled play from sibling?

			Discourse is predominantly about describing the child's actions as a pathology...
CHR04	193	Memo 234	Imparting critical information (landing a bombshell), but then smoothing over it...
CHR04	198	Memo 235	If Mother says something to support diagnostic view – seems then ok & accepted; If Mother says something more difficult to fit into the overall picture - needs to be (professionally) observed, to be believed/acted upon...
CHR04	196	Memo 236	Making such statements is perhaps indicative of the manner in which much assessment/discussion has been carried through: statements made, then left as others' responsibilities...
CHR04	197	Memo 237	The final detail is often the most significant - which here seems to need to be attended to... however, smoothed over, and professionals carry on with next business...
CHR05	11	Memo 238	Indicative that since the referral, nothing much has happened, so whether the referral information is still current...
CHR05	14	Memo 239	This child has been through the experience of a new baby/ sibling, during the assessment period- maybe explaining why the parent would have missed appointments... Do professionals make that link?
CHR05	15	Memo 240	Had no idea...
CHR05	61	Memo 241	No real surprise, at that...
CHR05	110	Memo 242	Feeling abandoned - lost professionals; left to do a difficult (thankless?) task/job.
CHR05	41	Memo 243	Lacking in actual descriptions of child's play skills
CHR05	40	Memo 244	Discussing that already seen Paed means can go ahead quite quickly. ADOS is to rubber stamp what Paed has already confirmed.
CHR05	17	Memo 245	Reading out aloud from paperwork...
CHR05	28	Memo 246	Using estimation so can continue; not preferring to wait for assessment over time.
CHR05	49	Memo 247	(admission of) difficulty to achieve continuity; acts as confound to the (ultimate) goal of assessment over time, where little & often enables a view of whether the child can make progress... what is 'some time' - for how long? how many appointments? and how many were missed?
CHR05	50	Memo 248	Professionals making links that safeguarding concerns can be affective of parental capacity for continuity towards child intervention

CHR05	102	Memo 249	Like children - "I'm more important than you"! coming from lower status individual.
CHR05	120	Memo 250	In actual fact - what would working together mean? is there limited liaison from SWr, because of pervading belief of what the Centre do; not assumed to need to know of the CP matters? Lack of understanding of the impact of the CP concerns? Or assumption that the Centre staff will pick up the information from MARAC? Either way, the hiccups in gathering together details of influential factors in the child's background, does not hinder the continuation of applying ADOS and the assessment scoring.
CHR04	9	Memo 251	These facts that are exchanged between professionals, of family living, the parent's actions with child, are mentioned (described) but not apparently used... i.e. processed for the possible effect...
CHR04	14	Memo 252	Veracity of this; if the Uni did make such a claim - should they have (over-reaching themselves as to the purpose/objectivity of their research) and where is the evidence they said this to Mother? Why do the Centre profs pay particular attention to this - does it confirm their 'view' of the significance of people's status as 'must be ASD then' if the Uni thought so.
CHR04	39	Memo 253	Clutching at straws...?
CHR04	44	Memo 254	Paed does actually ask the most searching Qs - but to what purpose when the answers are less than complete?
CHR04	45	Memo 255	Mum's nice!
CHR04	53	Memo 256	Coercive talk by SpHV; Paed taking it in, contemplative; acquiescing - possibly because has established the view from Uni research team? Basically the Paed is being 'told' to give the diagnosis (rubber stamp); confirming cut-off point on ADOS and Uni research have also said...
CHR04	4	Memo 257	This is the most direct the Paed gets in giving a diagnosis
CHR04	177	Memo 258	A proactive Centre - encourages research... during researcher visits, have seen evidence of other researchers involved; reinforcing the perspective that they need to attract/draw in attention, ((re)affirmation of (self)importance) as otherwise would be left (abandoned) in this testing place of providing (difficult) diagnoses etc. which many might well not want to be involved with?
CHR04	179	Memo 259	??? what does this refer to??
CHR04	175	Memo 260	This is vague... what are 'support things'?
CHR04	184	Memo 261	Continuing with drive to write report which corroborates ASD diagnosis. Although discussion has highlighted gaps in knowledge base... profs do indicate they will follow through on highlighted, concerning areas, but also still pursue intent to diagnose - potentially they would need to exclude these factors first - and then revisit whether diagnosis is appropriate?

CHR04	205	Memo 262	Paed - 'rubber stamps' decision; directs what other's need to do; appearing to abscond responsibility following corroboration of diagnostic decision...leaves SpHV with this 'responsibility', rather than (making) taking it and dealing with it personally...
CHR05	36	Memo 263	Generally though, the ADOS assessor + paed view = diagnosis. Either/or corroborates the other?
CHR05	15	Memo 264	SpHV, hasn't met child but knows all the history...
CHR05	133	Memo 265	Possible linked explanation - seeking containment away from child's experiences at home re Domestic Violence?
CHR05	137	Memo 266	Still surmising? Doesn't know? Not clear if child has been seen in nursery yet? Even if Qs is asked, it can't impact on the nature of the ADOS assessment...
CHR05	179	Memo 267	Flat, flat interchange, reflects child's characteristics they are describing
CHR05	200	Memo 268	Child can give response when high input made by adult - overlooked by SpHV / TCHR_7
CHR05	293	Memo 269	An emerging picture of this child's reaction to the adult's during his assessment...!
CHR05	268	Memo 270	A lot of emphasis on 'quality' of smile. What does this mean; appears lifted from ADOS criteria, but how then does a professional qualify as to the type of smile a child makes?
CHR05	73	Memo 271	Self-serving bias - supports bringing a very young child to a strange setting is justifiable
CHR05	382	Memo 272	Contrasts with detail at lines10:47 & 10:52
CHR05	273	Memo 273	Contradicts later phrase, at lines 16:00 - 16:03
CHR05	399	Memo 274	Professional interpretation is rigid against the criteria; no flexibility in seeing behaviours against one aspect of the ADOS can be used against another part of the ADOS. Is this further example of mirroring the nature of the child's difficulties ie child's restricted language/communication abilities = professionals' restricted interpretative range
CHR06	42	Memo 275	Later on, in the assessment phase, this mother is described to not have (sufficient?) reading skills of letters, such that there is talk of ringing to let her know about appointments.
CHR06	42	Memo 276	SLT reading composed letter for Mother aloud; is this a tacit form of joint decision-making, not really going to be questioned.
CHR06	9	Memo 277	Professional's nervousness; justifying decisions to SLT?

CHR06	14	Memo 278	SLT: recalling the decision/ letter...
CHR06	15	Memo 279	Resuming from original place (as overruled by SLT)
CHR06	16	Memo 280	A bit of jostling going on, over role importance. (SISS getting an opportunity to promote selves to manager). A little dig that the referral's come through to them - not from Centre personnel (although potentially it did originally but SLT had closed the case).
CHR06	10	Memo 281	There's nothing in this history 'take' that can assist profs to separate the needs of this child from the needs of other more affected youngsters with ASD?
CHR06	30	Memo 282	What are 'doctor things' - with yellowy bits of paper?? Implying might support SLT/Mngr sense of importance?? Allusion to the status of a Dr??
CHR06	7	Memo 283	Bringing the discussion back to focus on the child - moving away from centring on Mother's difficulties.
CHR06	34	Memo 284	Raises the fact of whether the child's hearing has been ok? Is able to follow a visual model but does not respond to the verbals?
CHR06	189	Memo 285	Difficult to see where links are made to the developmental level of the child? A child of nearly 6-yrs is very different to a child of 2- to 3- yrs? This child is more capable and he is also much older...
CHR06	6	Memo 286	Reflecting that this form of assessment might suit some, more capable, outgoing children - emphasises that the child who is less outgoing, dev delayed is more susceptible/vulnerable to meeting (labelling) criteria.
CHR06	17	Memo 287	Already been discussed...? off-tape?
CHR06	63	Memo 288	Mutual awareness that this hasn't been clarified yet...
CHR06	121	Memo 289	Conflicts with how eye gaze was interpreted for other cases
CHR06	158	Memo 290	TCHR_1 dominates these descriptions. SpHV is struggling to be heard... TCHR_1 keeps interrupting to make (assert) the descriptions of CHR06's play & behaviour.
CHR06	227	Memo 291	Why recommend Makaton for this skill level?
CHR06	300	Memo 292	ADOS set up like it's a Test - child doing it, only they have no idea that they are. Controversial! e.g. the phonics test in EYs is questioned, yet here it's ok to use this procedure with a child?
CHR06	318	Memo 293	Use of 'I know him' left hanging; a subtle reference to the position of the KWr who doesn't know the child outside of the Centre. As per reference to the demarcation of practice between SISS and Centre core 'team'. TCHR_1 alluding to be in the better position of really knowing the child, but

			defers to SpHV as the 'examiner' who's ultimately responsible... this persuasive dialogue leads to a climbdown by SpHV.
CHR06	339	Memo 294	Two cases described as hiding, getting into corners, going under the table - is this them trying to 'get away' from the experience ??
CHR06	348	Memo 295	A sense that Key professionals in the Centre are 'abandoned' to do the difficult task of diagnosis; a potential reflection of the families' experiences with the children's manifestations.
CHR06	385	Memo 296	Decisions seem to have gone all over the place with this child; are profs keeping their eye on the purpose or getting caught up in status jostling, as borne out by having the final say in deciding what's wrong with the child e.g. SLT saying "doing doctor things"...? Task of diagnosing: alluring as well as isolating. Profs feel abandoned but also seek to have the status. The System allows them get on with it Paed as officiator 'brought in' when it is appropriate.
CHR03	110	Memo 298	Pre-ADOS
CHR03	381	Memo 299	Post ADOS
CHR05	22	Memo 300	SpHV knows all the facts off the case file, not from 'knowing' the child...
CHR05	156	Memo 301	"he seemed happy enough with that an we didn't have anything else": Have they put all the toys away (in achieving standardisation?) such that there is only a choice of one set (pair of objects) - hence CHR05 was making use of what was available?
CHR06	36	Memo 302	Clarifying who provides support to child - indicator of higher needs? when an ISP rather than in-house.
CHR05	4	Memo 304	Although leading in reading out referral information etc, when signing is referred to other people seem to do it?
CHR03	35	Memo 309	Relation to Bion's view of time passing in the group?
CHR06	7	Memo 310	Referring to fact that if doesn't do the letter during Panel, it may not get done? Perhaps because of competing priorities, outside of Panel meetings, impinging on getting such letters done?
CHR06	49	Memo 311	Actually it seems that it was a problem that M didn't take a note because the child did end up delayed in the system
CHR06	20	Memo 313	TCHR_1 showing an alternative motive for the ADOS assessment; " <u>and</u> the assessments school have got" is used as an afterthought to describing own work, which seems the priority...

CHR04	48	Memo 315	Getting muddled... like the Mum in a muddle, has he/hasn't he ASD?
CHR06	17	Memo 317	Using 'buzz' words (single plans!)
CHR05	9	Memo 318	Do the professionals have the view that doing a standardised assessment (ADOS) requires an adult who can be objective. Knowing the child well - as if have conducted series of visits outside of Centre - means an adult can't then be objective during the assessment. Hence seen doing it 'cold'?
CHR05	59	Memo 319	Adults seen to protect each other... SpHV could say the assmnt continue another time, when observation information is available, but doesn't. Is that because of time pressures...? ** explore if measurement of outcomes (in NHS) can only be in relation to time taken in system? **
CHR03	21	Memo 321	No discussion about the difficulty for the child in strange environment with only her Mum around; having to deal with the assessment context...
CHR03	172	Memo 322	Already raised issues of speech and language understanding - professionals could make links that this might be a factor of the 'staring quality'
CHR03	280	Memo 323	Is this the closest the child gets to familiarity in this assessment context?
CHR03	286	Memo 324	Appears with targeted support/ intervention the child can learn? pick up on what adults are expecting? Does seem that as professionals describe child attributes they overlook to analyse the impact of their influence. Why would that be? (possible from taking a wholly in-the-child view?)
CHR06	378	Memo 328	Stammering? – from knowing that not expected to be making such assertions?
CHR06	47	Memo 329	M 'in tune' with pre-occupation of SLT and not troubling further for copies
CHR03	398	Memo 330	In the end, this was not arranged until well into the New Year
CHR05	31	Memo 331	FamCo seems often to be the port-of-call
CHR05	12	Memo 332	Knowing parents better than the child? "Lovely/ open parents", to the likelihood of ASD - parents will be expecting diagnosis? see link to lines 29-31.
CHR05	35	Memo 333	Parents following most immediate course to obtain the diagnosis...
CHR05	43	Memo 334	'And from what I've read': alluding to own 'expert' opinion...
CHR05	126	Memo 335	SpHV seems keen to bring TCHR's back to Centre; but they don't appear so keen on being drawn back...
CHR05	21	Memo 336	Repeated Qing
CHR05	88	Memo 337	SaLTee wanting to say something then? - was spoken loudly over?

CHR05	97	Memo 338	Describing - not analysing?
CHR05	151	Memo 339	SalTee responses are to agree positive descriptions; these are then counterbalanced by SpHV or TCHR_7 assumptions over the behaviour. SalTee uses 'mm' as is digesting their discourse/interpretation?
CHR05	197	Memo 340	As SalTee is raising an alternative description, echoing is used to discredit/nullify it...
CHR05	206	Memo 341	This phrase is a 'mirror' of the extent the description/ perspective of CHR05 is not heard by others
CHR05	245	Memo 342	the positive voice... 'drowned' out
CHR05	95	Memo 343	Right about what? when? - can be seen reinforcing TCHR_7 over SalTee? and further strengthening the Centre's position...
CHR05	212	Memo 344	SalTee uses repeating of positive descriptions of child's responses; gets excited at his response! Immediately counteracted by TCHR_7 making negative attribute - that was repetitive...
CHR05	280	Memo 345	Not seeing a child centred perspective, that this child might need to be trying to exert some of his own control to the situation, as he is surrounded by unfamiliar people, forcing his engagement?
CHR05	289	Memo 346	With no real purpose...
CHR05	332	Memo 347	SalTee is encouraging this positive child description by SpHV; TCHR_7 acknowledges, but disbelieving too
CHR05	438	Memo 348	Thinking that SpHV is going to review the characteristics of the child's enjoyment; SalTee perks up, saying 'ok' - added interest? SpHV primary focus is to read out the medical descriptors... which leads to specifying the match to child's behaviour during ADOS and general conforming agreement.
CHR05	456	Memo 349	and links to line 461 (below)
CHR05	472	Memo 350	Is then assessed according to the SalTee's description from earlier, that was contradicted?
CHR06	37	Memo 351	As mngr of U6 assessments, EP is answerable to SLT, who is overall Centre mngr. Hence the deferring, sense of responsibility to be explaining...
CHR03	179	Memo 352	There were only adults present...
CHR04	9	Memo 353	Sighing is mirrored?
CHR02	70	Memo 356	From being overlooked

	0	... repetitive...	And as per code memo 'sniffs/sighs': a metaphor for the nature of the professionals' work...
	0	Sniffs/Sighs	as per code memo (repetitive) - all the profs 'pained' sniffing/sighing, a possible reflection of the monotony of their work - is that the mirroring of the nature of the child's difficulties... isolating type work ... links to a previous feeling of trying to draw in others to be more involved, but not successful, and being overlooked by SWrs generally and specifically (eg-CHR05).
	0	'As If' Diagnosing	Could be labelled 'virtual' diagnosis?
	0	Professional Assessment	From use of codes, apparent that to assess is the primary role/ focus, of the Centre. Profs sifting through +ve and -ve attributes of child and weighing them up... Actions seem to be about gathering together other people's information? The initial visit appears as a comprehensive parent interview; SISS provide the observation information (from setting) – (but differences between CHR05 & CHR06). ADOS is an assessment tool which appears as collating a descriptive feedback of the child (abstract looking) at what they did/ did not do, whilst on a (single) visit to the Centre.
	0	Reading out the referral information	SLT takes on this function
	0	Minding the spreadsheet	EP takes on this role
	0	Taking lead in initiating processes/ making introduction s	SLT takes on this role
	0	Making the written record of decisions	SLT takes on this role - or directs how SISS personnel do it (seeming to still keep 'control' in the sense that maintains dictation as to how it is done).
	0	Inviting SISS to 'bring' their concerns for an opinion	Maintains the System

7.5. CAQDAS PROGRAMME ANALYSIS

7.5.1. Key to Transcription Notations

Transcription Notations (after Bailey, 2008; Oliver et al 2005)

Font 8	<i>soto voce/</i> whisper
Font 11	‘normal’ volume
wordwithnospaces	quicker/ faster speech
(?)	talk too obscure to transcribe
Hhhh	audible outbreath
.hhh	audible in breath
[overlapping talk begins
]	overlapping talk ends
(.)	silence, less than ½ second
(...)	silence, less than 1 second
(2.8)	silence measured in seconds
≈	lengthening of a word/ sound
((sniff))	indicates non-verbal activity
Becau-	cut off. Interruption of sound
<u>he</u> says.	speaker emphasis
.	full stop or stopping fall in tone
:	stretching of preceding sound/ letter
=	no silence at all between sounds
(taps)	nonverbal noises/ sounds
?	rising intonation (questioning)
˘	rising intonation, middle/ end of word

7.5.2. MAXQDA CD-ROM

Copy of complete software data set.

[Not available in the electronic repository format]

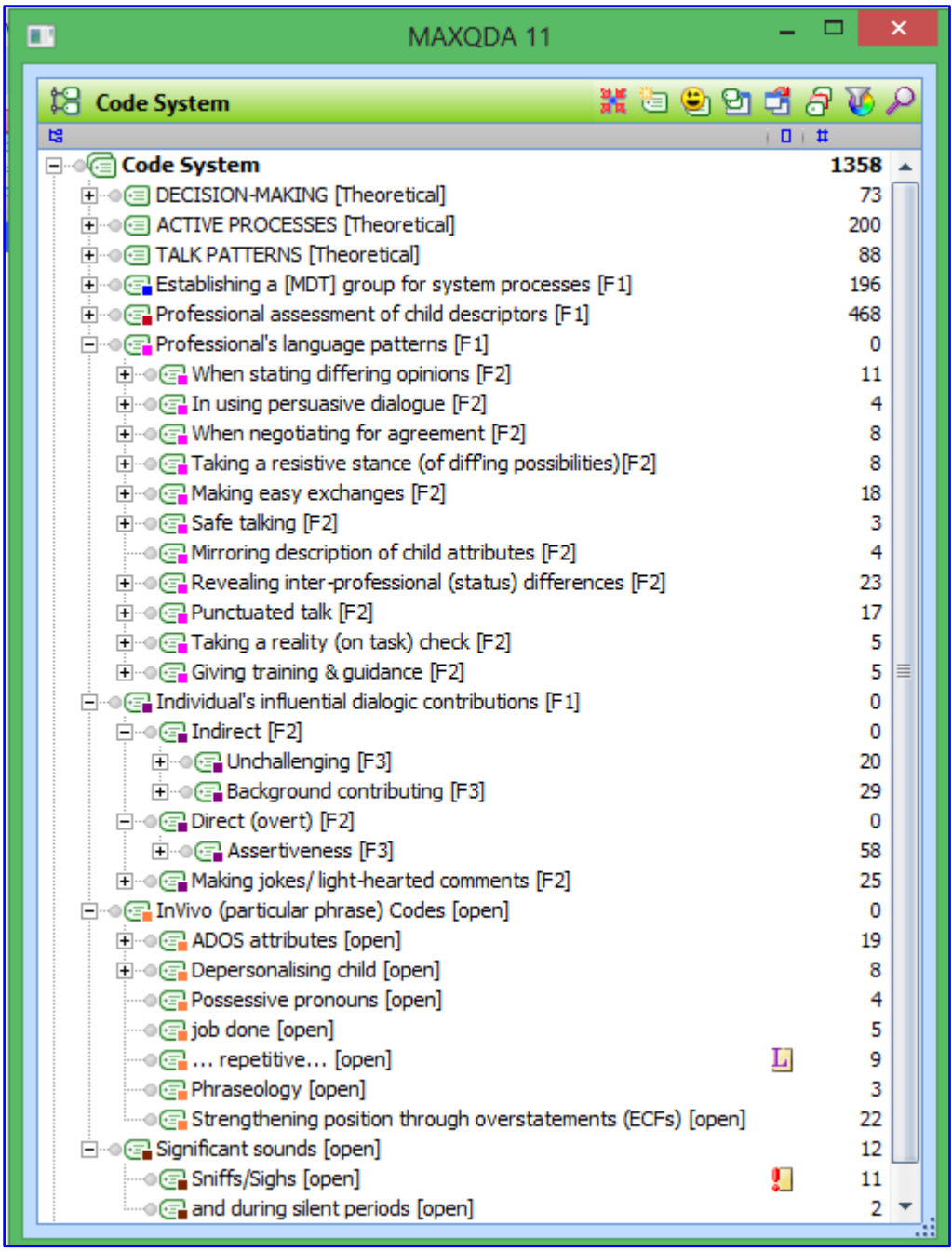
7.5.3. MAXQDA Screenshots

Focused Categories for *System processes & Assessment of child descriptors.*

Code Group	Count
Code System	1358
DECISION-MAKING [Theoretical]	73
ACTIVE PROCESSES [Theoretical]	200
TALK PATTERNS [Theoretical]	88
Establishing a [MDT] group for system processes [F2]	0
Maintaining procedures of a referral system [F2]	0
Centre referrals [F3]	35
Referrer details/ Background to referral [F3]	15
Making decision, from referral details [F3]	17
Recording detail of decisions made [F3]	41
Reviewing/ overseeing progress of child in system [F3]	16
Taking on contrib.functions/roles as part of System [F2]	40
Factors affecting profs. capacity within the System [F2]	0
Time Issues [F3]	14
Communication channels (Centre personnel/ SISS) [open]	4
Unexpected events/ issues - contn and adaptn. [open]	8
(Tavi. Research influence) [open]	6
Professional assessment of child descriptors [F1]	0
Reading/ weighing-up referral/ other info.reports [F2]	0
Listing child's symptoms [F3]	15
Attending to stated family history/ trait [F3]	6
Attending to family living details [F3]	8
Having decisions/ dev. history from Home Visit recs [F3]	11
Attending to child's reported developmental history [F3]	6
Significance of parent (mother) contribution [F2]	0
Profs using received info. off parent (mother) [F3]	43
Recounting knowing Mother [F3]	15
Frustration over parent attendance [F3]	13
Taking lead in assessments & decisions as keyworker [F2]	5
Keyworker acting as conduit for other involved profs [F3]	41
Revealing lmtd/ incomplete/ unclear info./ reportage [F3]	26
Gathering in markers/descriptors of child ability [F3]	11
Applying ADOS assessment processes to child in centre [F3]	60
Keywkr establishing primacy in assessment judgements [F3]	20
Cross-refing obs to medical criteria/ descriptors [F3]	137
Reaching outcomes following ADOS/ other assessments [F3]	23
Bringing to attn of Paediatrician to confirm diagnosis [F3]	15
Voicing an alternative position [F2]	13
Professional's language patterns [F1]	106
Individual's influential dialogic contributions [F1]	132
InVivo (particular phrase) Codes [open]	70
Significant sounds [open]	25

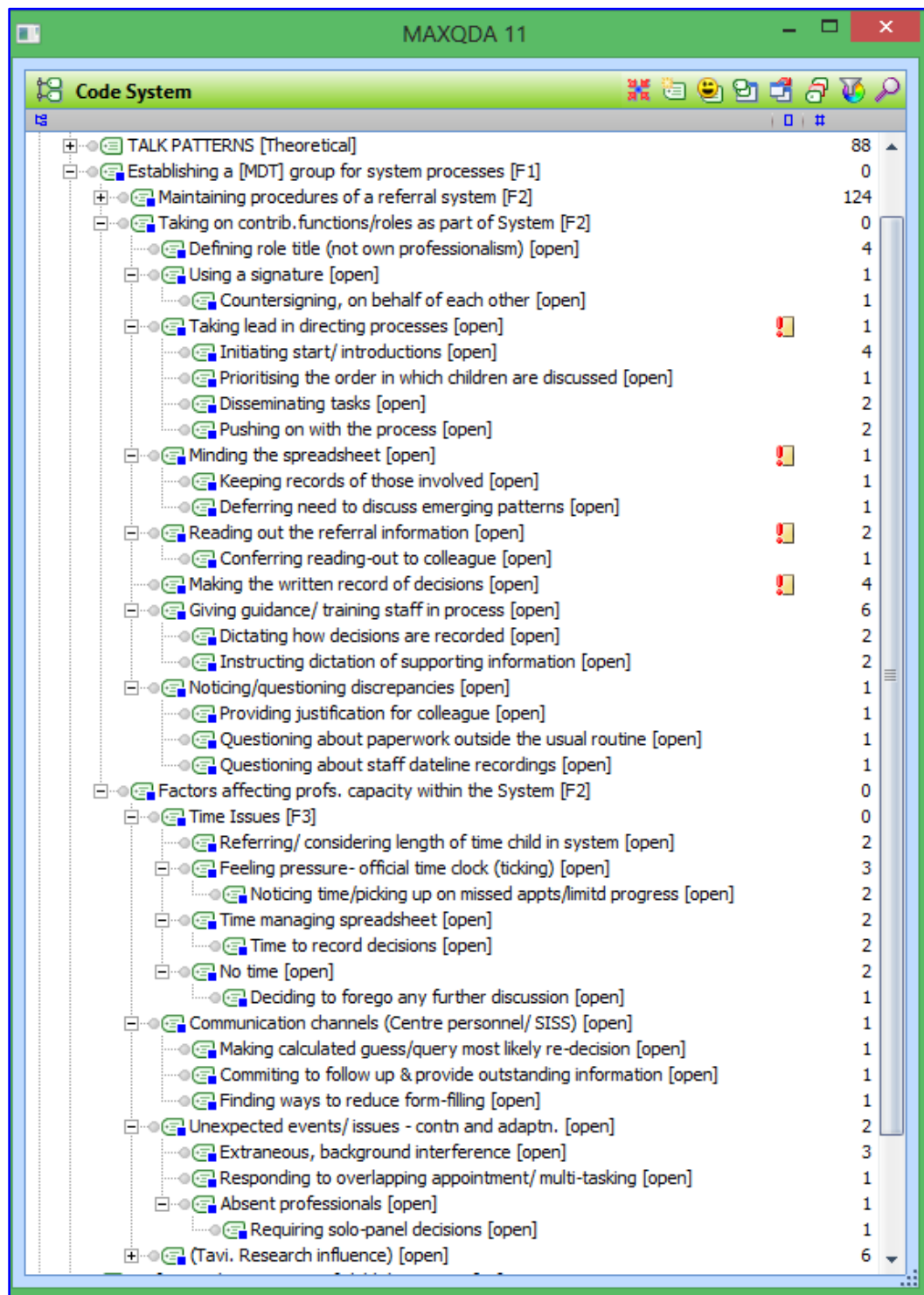
MAXQDA SCREENSHOT TO SHOW THE CODE GROUPS, *ESTABLISHING A [MDT] GROUP FOR SYSTEM PROCESSES* AND *PROFESSIONAL ASSESSMENT OF CHILD DESCRIPTORS* THAT FORMED TWO (OF FOUR) OF THE PRINCIPLE, FOCUSED CODE CATEGORIES

Focused Categories for *Language patterns & Individual dialogic contributions*.



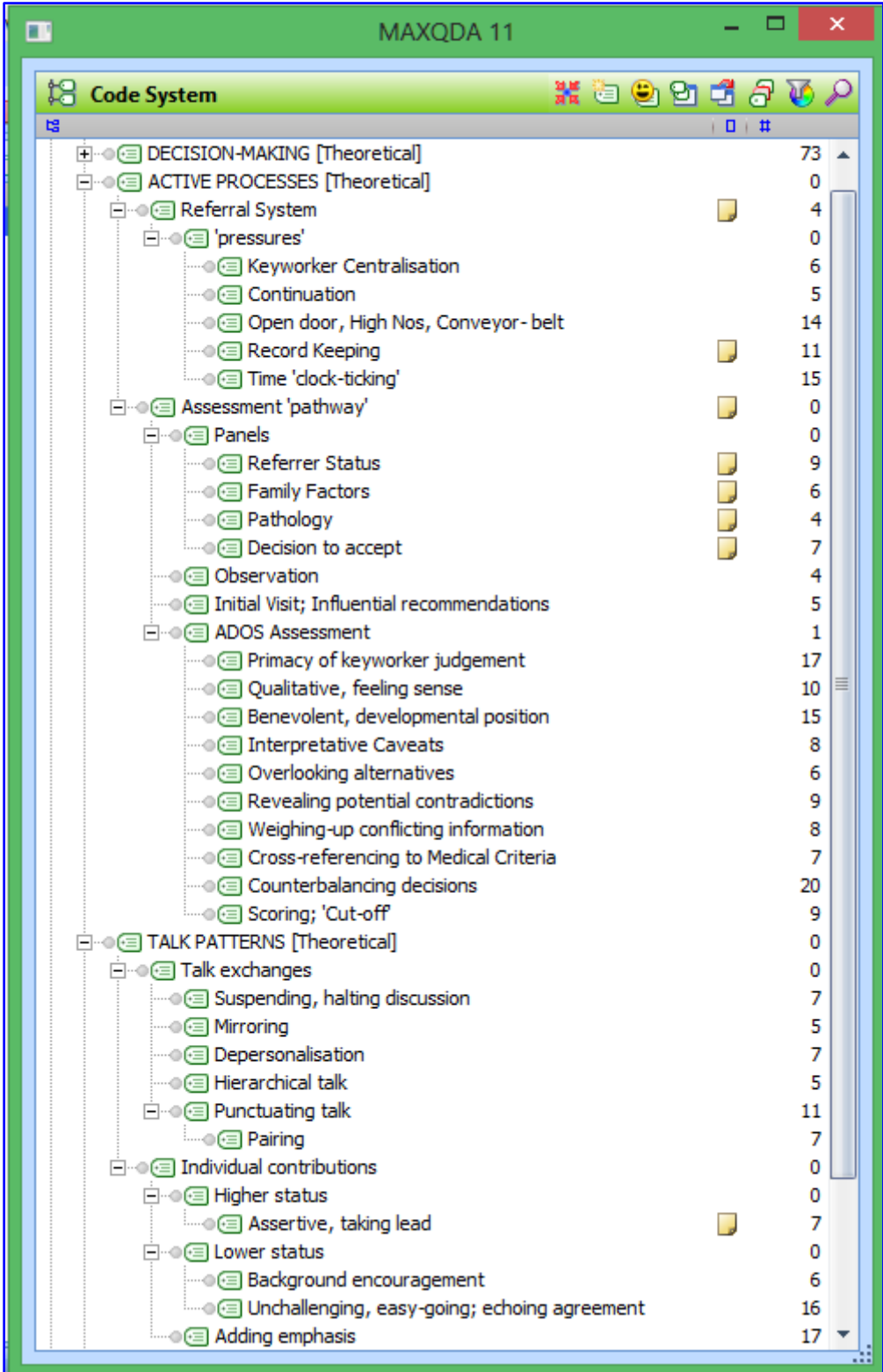
MAXQDA SCREENSHOT TO SHOW THE CODE GROUPS *PROFESSIONAL LANGUAGE PATTERNS* AND *INDIVIDUAL'S INFLUENTIAL DIALOGIC CONTRIBUTIONS* THAT FORMED TWO (OF FOUR) OF THE PRINCIPLE. FOCUSED CODE CATEGORIES

Illustrative example from two compact, focused category groups showing all the open-codes that formed beneath.



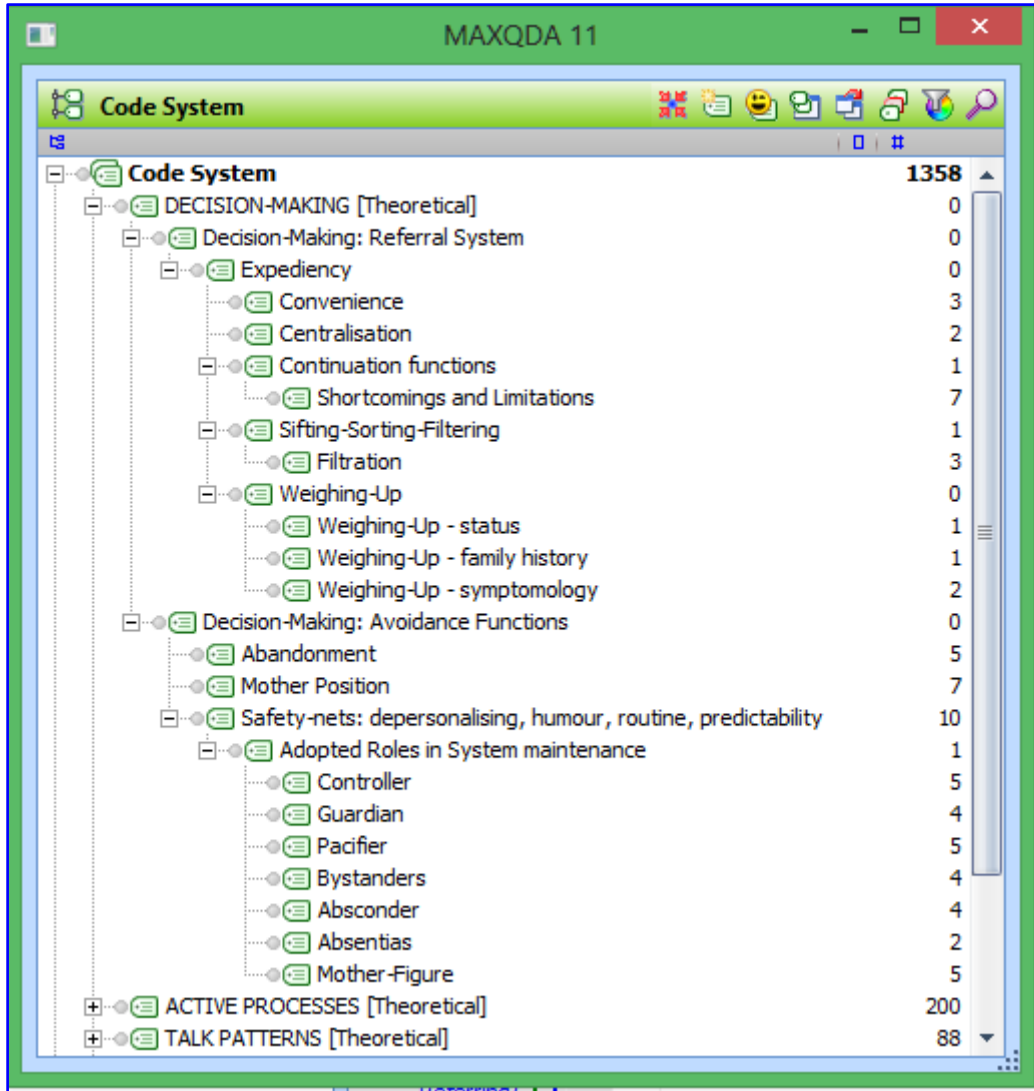
MAXQDA SCREENSHOT TO SHOW FULLY EXPANDED OPEN AND FOCUSED CODE GROUPS *TAKING ON CONTRIBUTORY FUNCTIONS/ROLES AS PART OF SYSTEM* AND *FACTORS AFFECTING PROFESSIONAL CAPACITY WITHIN THE SYSTEM* THAT FORMED TWO OF THE UNDERLYING FOCUSED CODE GROUPS

Theoretical Categories for *Active processes & Talk patterns*



MAXQDA SCREENSHOT TO SHOW THE THEORETICAL CODING OF *ACTIVE PROCESSES* AND *TALK PATTERNS*

Theoretical Codes for *Decision-making: Referral System & Avoidance functions.*



MAXQDA SCREENSHOT TO SHOW THE THEORETICAL CODING FOR *DECISION-MAKING* IN THE *REFERRAL SYSTEM* AND AS *AVOIDANCE FUNCTIONS*

Footnotes

¹ At the time this research commenced, Labour Government was in power and the Department for Children Schools and Families in operation. Subsequent to the 2010 General Election and the formation of Conservative-Liberal Democrat Coalition Government, responsibility for Education and Children's Services renamed from the Department for Children, Schools and Families (DCSF) to the Department for Education (DfE). This government has introduced a new Code of Practice of statutory support in the form of Education, Health and Care plans, for children with special needs in educational settings. Recommendation continues for joint working of different professionals, for example as indicated in the assessment and planning process, it should 'bring together relevant professionals to discuss and agree together the overall approach' DfE. (2014, p. 148).

² For reasons of anonymity and confidentiality, this citation source is not reported.

³ ICD-10. (2004). *International statistical classification of diseases and related health problems* (10th revision, 2nd ed.). Geneva: World Health Organization.

⁴ *Diagnostic and statistical manual of mental disorders*. Widiger, T. A. (1996). *DSM-IV sourcebook*. Washington, DC: Published by the American Psychiatric Association

⁵ Publication of the new Diagnostic and Statistical Manual (DSM5) occurred in the latter period of the study however, assessment practices captured for these child cases still related to DSM4 and ICD10. The content for ICD10 remains unchanged with this the preferred criteria described used by Centre professionals in their child assessments.

⁶ Parents have reported specifically to value receiving assessment and the provision of support for their child/young person. Conversely, guidance states this is not always a priority for professionals because of pressure to reduce waiting times and see as many children as possible: 'families consistently feel let down by the lack of support and information during the diagnostic assessment' (NICE, 2011, p. 192).

⁷ Social Constructionism views individuals as born into a preconceived world of meaning, 'we inherit a 'system of significant symbols' by which 'culture is best seen as source rather than result of human thought and behaviour' (Crotty, 2003). Emphasis is on production of purposeful knowledge as constructions of understanding, with language the medium to transmit thoughts and feelings and provide the means to structure how the world is experienced (Burr, 2003). In this version of understanding, the social context is at the centre of meaning making, with knowledge creation a shared production going beyond individual meanings, to an intersection between individual meaning, social structures and power (Burr 2003).

The approach contrasts slightly with Social Constructivist positions, which prefer individualistic accounts to meaning making, in a social context.

⁸ Professionals felt the first consented-for child case (CHR0) was not suitable to put forward for the study. The second child consent received from parents (CHR01) moved through the Centre assessment 'pathway' without capture of professional discussions and there was therefore no transcription data concerning his assessment. This child case however did inform toward theoretical sensitivity through the contents of the case file.

⁹ Symbols, e.g. 📄, found within the MaxQDA screenshots indicate Memos captured by the researcher during coding and analysis. Code memos that appear in the findings section are shown cross-referenced, in the appendices or in the particular place in the software analysis on CD Rom.

¹⁰ Explanation of gerunds shows: 'Because they are nounlike, we can think of gerunds as names. But rather than naming persons, places, things, events, and the like, as nouns generally do, gerunds, because they are verbs in form, name activities or behaviors or states of mind or states of being' (Kolln & Funk, 1998, p. 123).

Likewise, explanation finds: 'A gerund is derived from a verb by adding the suffix -ing. The result is still a verb, and it exhibits ordinary verbal properties, such as taking objects and adverbs. For example: In football, deliberately tripping an opponent is a foul. Here the verb trip occurs in its gerund form tripping, but this tripping is still a verb: it takes the adverb deliberately and the object an opponent. However, the entire phrase deliberately tripping an opponent, because of the gerund within it, now functions as a noun phrase, in this case as the subject of the sentence. So, a gerund is still a verb, but the phrase built around it is nominal, not verbal'. Retrieved from <http://grammar.about.com/od/fh/g/gerundterm.htm>

¹¹ See reflexive notes, p.230, where the Centre Manager explained (after analyses were complete) how the NHS grading structure applied to professionals in the Centre.

¹² See also reflexive notes, *April*, p. 224 and *October*, p. 226, recounting the EP as Team Lead, reflections on work with parents, including a particular experience concerning an appeal over practice.

¹³ For the select terms related to emergent findings, entered to databases and the key papers used, refer to Appendix 7.2.3., p.199.

¹⁴ The authors reported coding of 54 individual interviews across the eight teams (CAMHS, SEN and Social Care). Analysis of interview transcripts was conducted in NVivo for the emergent themes, however it was not specified which qualitative methodology was followed.

¹⁵ Literature searches were in three waves (May 2008, November 2009 and November 2010), from which review of 181 studies made. Studies included were without restriction, regarding source, language, type or year of reference.

¹⁶ The social worker's presence in Panel became more withdrawn from the time of national change (refer to (i), above) and introduction of political changes. Their role in MDT assessments and attendance in Panels was soon after described by the Centre Manager to be re-prioritised for their perceived more significant role in children's Safeguarding (see p. 230).

¹⁷ Discussions with the Centre Manager raised references to staffing issues. In the latter period of the research, FamCo left, as did a Speech and Language Therapist and Clinical Psychologist. The Manager reported it was very difficult to recruit replacements, as these professions generally preferred alternate practice opportunities (Speech and Language Therapist described to prefer clinical work and Clinical Psychologist, CAMHS work).

¹⁸ The *bystander effect* describes the social psychological phenomenon where individuals do not offer help in an emergency when other people are present. Theoretical accounts indicate an immediate or imagined presence of others exerts influence on helping because these others are involved in the situation at hand (Latane & Darley, 1970).