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SHARED LEARNING

Selected Examples from the Literature

by

Hugh Barr
and
Ian Shaw

A CAIPE publication

Published by:
CAIPE – the UK Centre for the
Advancement of Interprofessional Education

344 Grays Inn Road, London WC1X 8BP

First published 1995

ISBN 0 9520 830 1 9

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A Report from the Review of Shared Learning

commissioned by:
CAIPE – The UK Centre for the Advancement of Interprofessional Education

from:
The School of Social Studies at the University of Nottingham

and funded by:
The Nuffield Provincial Hospitals Trust

publication costs funded by:
CCETSW

March 1995

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FOREWORD

By Dr John Horder, CBE President CAIPE

This is the last of three papers from the Review of Shared Learning which CAIPE commissioned from the School of Social Studies at the University of Nottingham. The first by Hugh Barr was an analysis of some 50 interviews with people at the leading edge of developments in and bearing upon shared learning (Barr, 1994a). The second by Ian Shaw reported upon telephone surveys of shared learning "initiatives" in two English shire counties (Shaw, 1995a).

This paper summarises selected examples of such initiatives in the United Kingdom (UK) which have been subjected to systematic evaluation. It provides an overview. It is not a substitute for studying reports in the original. Rather it enables readers to select those most relevant to their interests and to focus their attention accordingly. The paper complements CAIPE's bibliography (Toase, 1993) which includes numerous other sources. The summaries are preceded by a commentary. After endeavouring to resolve problems of semantics, this paper takes a critical look at methodology, before comparing the selected examples in terms of their context, theoretical orientation, aims, curriculum, learning methods and outcomes.

As the authors would be the first to acknowledge, much remains to be done to inform our understanding of the relationship between means and ends in shared learning. Indeed, their work highlights the need to apply the most rigorous research instruments to present and future initiatives in shared learning. Meanwhile, qualitative findings from the Review are being checked against wider developments reported to CAIPE in the course of its second national survey of interprofessional education (Barr and Waterton, forthcoming), which will provide the first national overview since 1988 (Shakespeare et al.,1989).

March 1995

ACKNOWLEDGEMENTS

We are grateful to everybody who has helped us in gaining access to the literature, including staff in the University of Nottingham libraries, Leah Brecunier who undertook the initial stages of the library search, and Jenny Weinstein who contributed unpublished material from CCETSW.

John Carpenter and Dr Shula Ramon kindly gave us permission to quote work prior to publication.

Dr John Horder and Lonica Vanclay at CAIPE and Professors Robert Dingwall and Olive Stevenson at the University of Nottingham were once again generous with their advice. Their support and encouragement throughout the Review has been much appreciated.

Special thanks go to the Nuffield Provincial Hospitals Trust for funding the Review and to CCETSW for contributing to publication costs.

Hugh Barr
Ian Shaw

March 1995

ABBREVIATIONS

CAIPE	United Kingdom Centre for the Advancement of Interprofessional Education in Primary Health and Community Care
CCETSW	Central Council for Education and Training in Social Work
CETHV	Council for Education and Training in Health Visiting
COT	College of Occupational Therapists
CNAA	Council for National Academic Awards
DHSS	Department of Health and Social Security
DipHE	Diploma in Higher Education
DoH	Department of Health
ENB	English National Board for Nursing, Health Visiting and Midwifery
FHSA	Family Health Service Authority
GP	General Practitioner
HEA	Health Education Authority
LOTs	Local Organising Teams
NHSTA	National Health Service Training Authority
NSPCC	National Society for the Prevention of Cruelty to Children
NVQs	National Vocational Qualifications
PDG	Professional Development Group
PHCT	Primary Health Care Team
RCGP	Royal College of General Practitioners
UK	United Kingdom
WHO	World Health Organisation

LIST OF THE SELECTED EXAMPLES

See References for Complete Details

Reference numbers are given each time one of the selected examples is quoted in the Commentary.

BEFORE QUALIFICATION

Number	Author or Lead Author	Topic
1a.	Jacques	General Practitioners, Health Visitors and Social Workers during Practice Learning
1b.	McMichael	Community Workers, School Teachers and Social Workers
1c.	Carpenter	Doctors and Social Workers
1d.	Carpenter	Doctors and Nurses
1e.	Lucas	Professions Allied to Medicine
1f.	Gill	Branches of Nursing
1g.	Brown	Nurses and Social Care Workers in Learning Disabilities

AFTER QUALIFICATION

Number	Author or Lead Author	Topic
2a.	Jones	Team Development in Primary Health Care in Devon
2b.	Spratley	Health Education in Primary Health Care
2c.	Thomas	Team Development in Primary Health Care in Liverpool
2d.	Shaw	The Open University and Learning Disabilities
2e.	Cosier	Collaborative Inquiry in Child Protection
2f.	Stevenson	Collaborative Inquiry and the Care of Elderly People
2g.	Spratley	Collaborative Inquiry in Primary Health and Community Care
2h.	Stanford	Post Qualifying Studies in Child Protection
2i.	Shears	Post Graduate Studies in Mental Health
2j.	Woodhouse	Case Studies in Matrimonial Conciliation
2k.	Bolden	General Practitioner and Practice Nurse Trainers
2l.	Brown	Preparation for Practice Teaching

SUMMARY

This paper is based upon selected examples of shared learning in health and social care in the United Kingdom (UK). All were evaluated and aimed to promote collaborative practice. There the similarities ended. Some took place prior to qualification, most subsequently. Some were triggered by local needs and opportunities, others responded to national and international strategies. Some were work-based, others college-based. Some were brief, others extended.

All but a few predated radical reforms in health, social care and education, which have since greatly increased the occasions when health and social care professions study together. Recalling earlier "initiatives" serves to reassert belief in shared learning as a means to promote collaborative practice, at a time when competing arguments for its introduction threaten to lose sight of its original purpose (Barr, 1994a).

Underpinning for that belief came from social psychological, psychodynamic and organisational theories, applied by means of interactive learning methods and framed within common curricula.

Evaluations differed in their form and rigour. Some focused on process; others focused on outcomes. Some collected original data; others relied on second hand sources. Some presented their findings to critical view; others expected readers to take them on trust.

The evidence suggests that college-based shared learning can and sometimes does improve reciprocal perceptions between professions and, by inference, predisposes participants towards collaborative practice. It also suggests that work-based shared learning can have immediate impact upon service development, organisational change and collaborative practice. Sadly, these aims were not always fulfilled. Lessons can be learned as much from the disappointments as from the triumphs, lessons which apply both to the design and execution of future shared learning initiatives and of research to test their efficacy.

INTRODUCTION

The first paper in this series (Barr, 1994a) drew upon the spoken word. Based upon some 50 interviews, it compared arguments for shared learning in the context of radical reforms in health and social care, on the one hand, and in education, on the other hand. This paper draws upon the written word. It summarises reports on selected examples of shared learning which:

- were published since 1980;
- put initiatives in context;
- sought to further collaborative practice;
- were evaluated systematically;
- took place in the UK.

These criteria need explaining.

- Papers about the initiatives had to be published (in journals, monographs or books) so that readers could have access to the original material and check our summaries. Unpublished conference papers, internal documents and other grey literature were therefore excluded. The earliest was published in 1984, although some refer to initiatives started during the 1970s.
- Each example had to provide information about the circumstances surrounding the initiative to enable readers to make sense of findings.
- Furthering collaboration had to be an aim, but not necessarily the sole aim. (Others typically had to do with improving services, effecting organisational change, or rationalising educational provision.)
- Judgements about the effectiveness of the initiative had to be grounded in systemetic observation and evidence, not opinion.
- Initiatives had to be in England, Scotland, Wales or Northern Ireland.

An on-line library search unearthed disappointingly few initiatives which met these criteria, but more promising material had come to our attention during our earlier work, while colleagues helped in filling gaps. We look to readers and reviewers to point out our remaining sins of omission.

Every initiative drawn to our attention which met the criteria has been included. They are examples, not exemplars. Initiatives which have been evaluated may well be amongst the more systematic and the more sustained, but they are not necessarily the most imaginative nor the most innovative. Few can be said to be amongst the latest, given the time lag between action, evaluation and publication. Permission was, however, sought and obtained to use papers awaiting publication to bring the picture up-to-date.

All but two of the examples which met the criteria were exclusive to England. It would, however, be wholly misleading to conclude that shared learning is less firmly rooted in Scotland, Wales and Northern Ireland. On the contrary, our interviews in those countries had found impressive developments (Barr, 1994a).

Surprisingly, no reports on any of the growing number of multiprofessional masters programmes (Storrie, 1992) met our criteria, although we make some call upon them (Leathard, 1992; Pereira Gray et al. 1993; Westminster, 1994; Gorman, 1995).

As our search progressed, we were encouraged to find related work from overseas, notably from the United States. There was much from which UK teachers, trainers and researchers could learn, and to which we plan to return.

This then is not a comprehensive review of the literature of shared learning. Indeed, we doubt whether that would be feasible, given its exponential growth and the indeterminate scope of the subject. Weinstein (1994), however, has provided a lively and thought provoking overview, which locates shared learning in the context of changes in welfare ideology, social policy, professionalism and professional educational systems.

We have summarised each example as honestly as we can, neither gilding the lily, nor (authors may be reassured) writing a series of belated reviews. We have, however, included an overview about methodology to assist readers in weighing the evidence and to provide pointers to good practice.

COMMENTARY

Our purpose in studying the selected examples was to test and develop our understanding of shared learning which had begun to crystallise during the interviews (Barr, 1994a) and telephone surveys (Shaw, 1995) in earlier stages of the Review. With an eye to the future, we were looking for leads to help in designing CAIPE's UK survey (Barr and Waterton, forthcoming) and to refine instruments for evaluating shared learning.

Topics of particular interest to us included:

- circumstances which had triggered shared learning;
- theoretical orientations, which had informed the design of the initiative;
- aims, with particular reference to collaborative practice;
- curricular content, with particular reference to ways in which common needs were defined across professions;
- learning methods, with particular reference to ways of facilitating interactive learning between professions;
- outcomes, in terms of changes in attitude, perception or behaviour and, where applicable, in service delivery organisation.

Each of these six topics comprises a separate section of this commentary. It begins, however, by searching for firm ground in the "semantic quagmire" (Leathard, 1994) into which debates about shared learning all too easily sink. It then takes a critical look at the methodology employed to evaluate the selected examples, before returning to those topics.

Semantics

Like us, some of the selected examples used the term "shared learning" (Lucas, 1990, 1e; Carpenter and Hewstone, forthcoming, 1c; Stanford and Yelloly, 1994, 2h) and, in one case, "interprofessional shared learning" (Gill and Ling, 1994, 1f). Others opted for: "learning together" (Jones, 1986, 2a), "interprofessional education" (Carpenter, forthcoming, 1d; Shaw, 1994, 2d), "multiprofessional education" (Lucas and Davidson, 1995, 1e), "multidisciplinary training" (Jacques, 1a), "courses in collaboration", "joint courses" and "integrated courses" (McMichael, Molleson and Gilloran, 1984, 1b) and "collaborative inquiry" (Spratley and Pietroni, 1994, 2g; Cosier and Glennie, 1994, 2e; Stevenson et al. 1993, 2f).

Some sources employed different terms on different occasions, reflecting a general tendency to use them loosely and interchangeably. Others, however, devised quite precise meanings of their own. For example, CCETSW and the ENB distinguished between " shared learning" and " joint training", using the former to cover initiatives not jointly validated by them while reserving the latter for those which were jointly validated (Walton, 1989; Harding, 1991). Gill and Ling (1994, 1f) catalogued a list of seemingly precise terms found in the literature which invariably lacked general currency. Leathard (1994) and Rawson (1994) wrestled with well nigh endless permutations of prefixes

(e.g. "multi", "inter" and "cross"), adjectives (e.g."disciplinary" and "professional") and nouns (e.g. "education", "training", "learning" and "studies") in their efforts to impose clarity and order.

The key to greater clarity may lie in distinguishing more consistently between "interprofessional education" and "multiprofessional education". That seems to have been achieved more successfully in Continental Europe and in the United States than in the UK, albeit in different ways.

"Multiprofessional education", as used by the World Health Organization (WHO, 1978, 1986 and 1988) has been adopted by the European Network for Multiprofessional Education in Health Sciences (EMPE) (Goble, 1994a and 1994b) and is widely used in Continental Europe (Areskog et al. 1994) to describe initiatives involving three or more professions. Interprofessional education is used far less often and reserved for those initiatives involving only two professions.

"Interprofessional education" (or interdisciplinary) seems more common in the USA (Schmitt, 1994, Casto, 1994). There, multiprofessional appears to be used where professions learn side by side, reserving interprofessional for those occasions where they learn from and about each other (Casto and Julia, 1994). In the UK, CAIPE makes the same distinction as it advances the development of interprofessional education within multiprofessional education. We adopted "shared learning" in an attempt to avoid premature demands to clarify terms before concepts. We used it to cover "all opportunities where two or more professions within and across health and social care studied together" (Barr, 1994a). In the event, we found that others often reserved it for those occasions where there was evidence of a quality of sharing between the parties (bringing us back to the distinction between "inter" and "multi"). The priority, as we see it, is not to negotiate an agreed vocabulary, but to distinguish between characteristics of types of shared learning.

Methodology

Authors differed in the degree to which they exposed their methodology to critical review and backed assertions and arguments with evidence. Some obliged their readers to take methods and data on trust. Happily, others spelt out both in considerable detail (McMichael, Mollen and Gilloran, 1984, 1a; Gill and Ling, 1994, 1f; Shaw, 1994, 2d; Carpenter, forthcoming,1d; and Carpenter and Hewstone, forthcoming,1c). It is their findings that plainly carry most weight, while the methods which they tested are available for others to replicate.

Evaluation took many different forms. Most of the selected examples collected original data, although some also called upon secondary sources (often undisclosed). This applied, for example, when the researcher was brought in at a late stage (Brown, 1994, 1g) or the evaluation covered numerous brief initiatives (Spratley, 1990a and 1990b, 2b).

The focus of the evaluation typically included one or more of the following:

- programme planning, development and delivery
- the learning process

- participants and their participation
- participants' satisfaction
- participants' self-assessment of their learning
- changes in participants' attitudes, perceptions and/or knowledge
- impact upon participants' practice.

Data collected included observation of planning, organisation and teaching (Stanford and Yelloly, 1994, 2h), write-ups by participants' of their case studies, tape recordings of groups and consultants' logs (Woodhouse and Pengelly, 1992, 2j), and participants' diaries and personal profiles (Stanford and Yelloly, 1994, 2h).

Questionnaires recorded participants' satisfaction with course content and delivery, and practical arrangements. Some also included questions about the degree to which the initiatives had met their stated objectives, or ways in which participants thought that they had benefited. Others collected data about changes in attitudes or perception, using semantic differentials, which Shaw (1994, 2d) concluded were the most promising means to evaluate shared learning. Scales invited participants to record attitudes to, or perceptions of, their own and other professions (Gill and Ling, 1994, 1f; Carpenter and Hewstone, forthcoming, 1c; and Carpenter, forthcoming, 1d). Repertory grids were also used.

Participants were typically asked to complete questionnaires at the outset and at one or more stage during their courses. Response rates fell off with succeeding requests (Gill and Ling, 1994, 1f; Stanford and Yelloly, 1994, 2h). This prompts many questions, not least whether those who responded were those whose experience had been more positive, in which case findings might be skewed. Even more problematic was an attempt to elicit retrospective, current and prospective evaluations of participants' practice at the same time (Shears et al. 1995, 2i). Only one example included a follow-up questionnaire (Shaw, 1994, 2d). His findings indicated how important (if uncomfortable) it will be in future to build in such follow-up before claims are made about the lasting benefits of shared learning.

Questionnaires were sometimes complemented by interviews with participants and teachers (Stanford and Yelloly, 1994, 2h), and with other stakeholders. Brown (1994, 1g), for example, interviewed representatives of health and social services departments, colleges and validating bodies. Line managers were sometimes included.

Shears et al. (1995, 2i) brought in users and carers to help in designing the instruments and as respondents. Their experience, however, demonstrates how problematic this may become when researchers feel constrained from revising users' and carers' contributions in more rigorous research terms.

Some authors warned against the hazards of reading too much into findings based upon small numbers (Stanford and Yelloly 1994, 2h), but others dealt in quite large numbers, which offered more statistical credence (McMichael, Mollen and Gilloran, 1984, 1b; Gill and Ling, 1994, 1f; Carpenter and Hewstone, forthcoming, 1c; Carpenter, forthcoming, 1d).

The impact of college-based initiatives on collaborative practice is hard to assess. While attitudes and perceptions may change during the course, other variables may

intervene between its end and participants' involvement in collaborative practice. No doubt recognising this hazard, most college-based initiatives limited attempts to measure outcomes within the confines of course objectives.

Work-based shared learning may, however, be integral to change, change which can be observed and measured during and immediately following the initiative (Thomas, 1994, 2c; Cosier and Glennie, 1994, 2e; Stevenson et al. 1992, 2f).

Putting the Examples in Context

Local circumstances prompted many of the initiatives. In Exeter it was the dearth of continuing professional development opportunities for health professions in scattered rural areas (Jones, 1986, 2a). In Liverpool it was the pressing need to improve primary health care in deprived inner city areas (Thomas, 1994, 2c). In Thamesmead it was the flush of enthusiasm to forge collaborative practice in a new town (Jacques, 1986, 1a). At Moray House, Edinburgh, it was the discomfort of teachers who witnessed the distance between students preparing to enter different professions (McMichael, Molleson and Gilloran, 1984, 1a). At Suffolk College it was the opportunities created by the introduction of a Diploma in Higher Education: Professional Studies (Gill and Ling, 1994, 1c). At University College, Salford, it was bringing together undergraduate professional courses within a single School of Health Sciences (Lucas, 1990, 1e; Davidson and Lucas, 1995, 1e). At the Marylebone Centre Trust, it was involving practising professionals in identifying priorities for future shared learning initiatives (Spratley and Pietroni, 1994, 2g).

Yet these and other initiatives were clearly taken within a critical understanding of the significance of international and national developments. While the link between international and UK policy is often tenuous, the inspiration for a number of initiatives can be traced back to the lead given by the World Health Organization (WHO). Its Alma Ata Declaration (WHO, 1978) called for an understanding of health which was wider than the medical model. That would only be possible with a more broadly- based workforce and teamwork. Multiprofessional education was invoked to promote such collaboration (WHO, 1988).

UK policies for primary health care, whilst not derived directly from those of the WHO, do reflect similar concerns and have led to progressive extensions of functions. These have necessitated a more diverse complement of staff, and developments in teamwork and teambuilding (Pritchard and Pritchard, 1994). An important development was the UK Government's strong support for the WHO's Ottawa Charter (1986) which focused upon key health principles, including a recognition of the importance of intersectoral and multidisciplinary collaboration in primary health care.

Prevention and health education were central to the case made by the WHO (1978) and have also featured prominently in moves towards a wider view of health in the UK (Secretary of State for Health, 1992). In response, an ambitious programme of workshops was instigated by the Health Education Authority nationally, but delivered regionally and later locally (Spratley, 1990a and 1990b, 2b; Lambert, 1988, 1991 and 1994). Collaboration in prevention and health education was to prove a powerful and positive reinforcement in developing teamwork in primary health care.

The WHO also encouraged multiprofessional education at undergraduate level, prompting seminal work at Linkoping in Sweden (Areskog, 1994a and 1994b). Amongst initiatives in the UK, those at University College, Salford, sprang most obviously from that tradition, the influence of Linkoping (and Adelaide, Australia) being generously acknowledged (Davidson and Lucas, 1995, 1e). Yet national policies seem to have been at least equally influential, notably moves to establish common studies for professions allied to medicine (National Health Service Training Managers, 1986).

Multiprofessional education at postgraduate and masters level seems also to have taken much of its inspiration from WHO (1988) although here, too, more immediate considerations are evident. Most of those courses set out to strengthen academic foundations in the health and social sciences. According to Storrie (1992), only one was started with the express intention of cultivating collaborative practice, but others subsequently incorporated that into their objectives. The secret behind the popularity of many of these courses seems to have lain in responding to latent ambitions to enhance the status of the professions included vis a vis others.

Government policy for shared learning and collaborative practice has perhaps been most fully developed in the field of learning disabilities (then called mental handicap). Based upon much the same concern as in primary health care to move beyond a medical model, a series of shared learning initiatives followed in the wake of the Jay Report (1979). Jay had argued for a social not medical model to care for people with learning disabilities in the community as long-stay hospitals were run down. Acting upon that conviction, it had recommended that responsibility for training mental handicap nurses be transferred from nurse education (under the then GNCs) to social care education (under CCETSW). That recommendation met angry and implacable opposition within nursing and from pressure groups. The former reasserted the need for a nursing (as distinct from a medical) model. The latter favoured an educational model. Neither favoured a social model, a term held to imply passive rather than purposeful care. Faced with an impasse (and a situation in which 80% of mental handicap care staff were in nursing), Secretaries of State rejected Jay's recommendation, calling instead upon the GNCs and CCETSW to establish a Joint Working Group to look at present and future learning needs of staff working with people with learning disabilities. The Group's remit was to consider the feasibility of introducing common elements in training programmes under the auspices of the Councils.

In spite of positive recommendations for combined qualifying courses (GNCs/CCETSW, 1982), only two initiatives got off the ground (Walton, 1989; Brown, 1994, 1g). Recommendations for similar developments in in-service training (GNCs/CCETSW, 1983) generated more initiatives and reports about them abound (Brown, 1992; Clarke, 1992). Only one of the latter, to our knowledge, has been evaluated (Shaw, 1994, 2d), namely an Open University course entitled "Mental Handicap: Patterns of Living" (P555). This was designed to promote new models of care and cultivate collaboration between professions and with users and their carers.

Parallel developments in shared learning might have been expected between learning disabilities and mental health, given that the same moves were taking place in both these fields to close long-stay hospitals and to develop care in the community. Fewer shared learning initiatives seem, however, to have been launched in mental health,

only one coming to our attention which met our criteria for inclusion (Shears et al. 1995, 2i)

Pioneering initiatives in learning disabilities paved the way for others to assist in implementing the NHS and Community Care Act, 1990. However, Carpenter and his colleagues (Carpenter et al. 1991) found wide variations between seven English "sites" in the extent to which they were in a position to call upon experience from earlier initiatives, although groups had been established between health and social services in most of them to assess training needs and to develop joint initiatives. Training strategies needed, they said, to embody common values and a shared philosophy, to be integrated into the planning and managing of services, to build bridges between agencies, and to recognise that joint training provided a model for joint practice.

Invoking shared learning to promote collaboration has perhaps been most clear cut in child protection. Failures of trust and communication between professions have been cited in a catalogue of official enquiries as reasons why warning signs were not spotted and action not taken soon enough to prevent abuse and sometimes death of children (see, for example, Colwell, 1974; Beckford, 1985; Kimberley Carlile, 1987 and Cleveland, 1988). Government has commended shared learning in child protection as a means to engender trust and to improve communication (Department of Health, 1988 and 1991) and included joint training within the brief for Area Child Protection Committees. Much shared learning has resulted, but only one evaluation met our criteria for inclusion, namely Stanford and Yelloly (1994, 2h), who report on two pilot courses mounted for the ENB and CCETSW.

Many of the earlier examples date from a time when shared learning was still very much the exception. That remains so for qualifying education, but much less so for continuing professional development. The speed and extent to which continuing professional development is being integrated results from the combined impact of changes in the commissioning of education and training, in the deployment of the health and social care workforce, in the reform of vocational education and training, and in college organisation

Devolution of training budgets to health authorities (Department of Health, 1989) favours the commissioning of training in organisational rather than professional terms (Beattie, 1994a). In both agencies and colleges, joint training is becoming the norm. While some registration and validating bodies still tend to be wary, the Royal College of General Practitioners is noteworthy for its support of shared learning after qualification. Collaboration between CCETSW and the National Boards has made significant strides towards shared learning for social workers and nurses, as examples from child protection (Stanford and Yelloly, 1994, 2h) and learning disabilities (Brown, 1994, 1g) show, while one for practice teachers has also included occupational therapists (Brown, 1993, 2l).

Reorganisation of health and social services has created new roles which apply to staff from various professions and none. They result, for example, from the devolving of budgets, and the introduction care management, as well as from the purchaser/ provider split, and mechanisms for quality assurance and control. Under the banner of "skill mix", service managers want a more flexible workforce, less hidebound by professional boundaries (Carrier and Kendall, 1994; Mackay, Soothill and Webb,

1994; Owens and Petch, 1994; Leathard, 1994). These trends combine to encourage the purchasing of training in terms of organisational rather than professional needs and priorities.

How far and how fast these trends impinge upon qualifying courses will have much to do with the readiness of the professions to embrace National Voluntary Qualifications (NVQs). Already, NVQs are well established at para-professional levels in health and social care (Carpenter et al. 1991; Kelly et al. 1990; Hevey, 1992). Barr (1994b) has speculated that impending extension of NVQs to include qualifying courses for (at least some) health and social care professions may result in more frequent shared learning, for example, between nurses, social workers and professions allied to medicine, but that the more established and prestigious professions, including medicine, may be unaffected for some considerable time. On that assumption, some of the initiatives reported here (Gill and Ling, 1994, 1f; Lucas, 1990, 1e; Davidson and Lucas 1995, 1e; Brown, 1994, 1g) become, in effect, pilots for larger scale initiatives in future.

With or without NVQ, centripetal forces are bringing related professions closer together. In social work, the first generic courses in the fifties and sixties combined students from, for example, child care and probation, leading in the seventies to integrated courses. In nurse education, Project 2000 provided the framework for shared learning between branches of that profession (Gill and Ling, 1994, 1f) and their respective teachers (Wall, Clifford and Hicks, forthcoming) although separate professional identities within nursing remain strong. For the Professions Allied to Medicine, developments at Salford and elsewhere may herald the beginnings of similar moves towards closer integration. The scene may therefore be set to rationalise families of health and social care professions into fewer but bigger "groupings".

Integration of specialist professional colleges into the mainstream of higher education is creating conditions favourable to shared learning, while modularisation makes it easier to combine student groups and market forces favour broadly-based courses.

So the context in which the selected examples are being reviewed in this paper is different from that in which all but the most recent happened. While the case for shared learning before qualification still has to be argued (Barr, 1994a), that for shared learning after qualification has largely been won. However, as such learning becomes more widespread, so its aims, content and methods become more diffuse. The challenge is now to select and develop those shared learning initiatives capable of promoting collaborative practice by refining their objectives, content and methods.

Theoretical Orientations

Examples differed in the degree to which they were grounded in theory and, if so, their theoretical orientation.

Drawing upon earlier work in the United States (Szasz, 1969), credit goes to McMichael for bringing theories from social psychology into shared learning in the UK (McMichael and Molleson and Gilloran 1984, 1b), while Carpenter (Carpenter and Hewstone, forthcoming, 1c; Carpenter, forthcoming, 1d) reintroduced them and brought them more closely into shared learning for health and social care.

Social psychologists had argued that negative stereotypes hindered interprofessional communication (Bruce, 1980 and 1982). People liked those who were rewarding to them (Berkowitz, 1975), while the approval of others reduced anxiety and enhanced esteem (Aronson and Linder, 1965). Stereotypes needed be neither negative nor irrational, rather means of ordering the social environment, while preserving and defending people's value systems (Tajfel, 1981). Crude attempts to strip them away, without offering something positive in their place, would therefore be of little or no lasting benefit. Viewed thus, the goal of shared learning was to improve mutual understanding and respect by engendering positive perceptions in place of negative. That made it easier to surrender unhelpful stereotypes.

Woodhouse and Pengelly (1991, 2j) offered an alternative orientation from the psychodynamic theories developed with their colleagues at the Tavistock Institute for Human Relations (Menzies Lyth, 1970; Mattinson and Sinclair, 1979). They extended understanding of transference between patient and worker to situations where more than one worker was involved. They illustrated how this affected relationships between workers and, writ large, between professions and between agencies. Anxiety generated by stressful situations prompted workers to retreat behind rules, procedures and entrenched attitudes and relationships (Jacques, 1951 and 1955; Menzies Lyth, 1970), which impeded interprofessional and interorganisational collaboration.

Viewed thus, the key to better collaboration lies in reducing occupational anxiety and thereby the need for such defence mechanisms. Yet all professions are under increasing pressure to implement new policies, to cope with recurrent reorganisation and to adjust to new styles of management. If Woodhouse and Pengelly's analysis is correct, the signs could hardly be more ominous at the very time when the professions are being exhorted to collaborate more closely to implement Government's policies.

Psychodynamic influence can also be seen in other shared learning developments. For many years the Tavistock Institute's Leicester conferences have helped professionals from a range of backgrounds to gain insight into behaviour, especially their own behaviour, in groups. Working with the Tavistock Clinic, the Marylebone Centre Trust has developed a more eclectic and pragmatic model (Pietroni, 1993) and extended it to include interprofessional and interorganisational behaviour. A rolling programme of residential courses, under the title "Pride and Prejudice" (Marylebone Centre Trust, 1993) involves participants from a range of professions in intensive interactive learning in small and large groups over a five day period.

We had expected to find more references than we did to organisational theory. While Salford referred to its inclusion in the curriculum (Lucasand Davidson, 1995, 1e), none of the selected examples seemed to taken it as a theoretical orientation in designing the course. We did, however, find extensive discussions elsewhere of the relevance of organisational theory in understanding collaborative practice.

Hudson (1987) drew upon American sources from management and the sociology of the professions to explore the significance of interorganisational behaviour. Given the cost in time and loss of autonomy, he said, motivation to collaborate rests upon the extent to which it realises each organisation's goals. Similarities of function, structure and values lead to more extensive and stable exchanges, while "people-processing" organisations are more likely than "people-changing" organisations to be involved in

collaborative activity. Collaboration, he concluded, differs in its degree of formalisation, official sanction, intensity, reciprocity and standardisation, while strategies for its promotion may be co- operative, incentive-driven or authoritative. Reviewing literature bearing upon collaboration in child protection, Hallett and Birchall (1993) provided further access to the literature of organisational theory as it relates to understanding the concept of coordination.

These theoretical orientations make uneasy bedfellows. They fall far short of a coherent theoretical framework for shared learning, but, together, they demonstrate the potential dividends in applying theory from the mainstream of education, management and the social sciences. It is from such perspectives that further progress seems most likely to come in understanding and harnessing the dynamics of shared learning.

Aims

All the examples had to include furthering collaborative practice amongst their aims to meet our criteria for inclusion. In some, this meant modifying participants' attitudes to, or their perceptions of, one another, the assumption being that this would lead to improved collaboration. In others, aims related directly to practice. Initiatives in learning disabilities, for example, promoted a new **model** of care (Brown, 1994, 1g; Shaw, 1994, 2d). Initiatives in both learning disabilities (Shaw, 1994, 2d) and mental health (Shears et al. 1995, 2i) promoted a **philosophy** which put users and carers at the centre of decision making. Promoting health education put **service development** and **public education** at the centre (Spratley, 1990a and 1990b, 2b; Thomas, 1994, 2c). Each of these amounted to a rallying call for participants, regardless of profession, to join forces and work together.

In Birmingham (Gorman, 1995) a multiprofessional masters course aimed to create a microcosm of collaboration in professional practice. The course was designed to test out the realities of collaboration by means of reflection, evaluation and critical discussion of practice. The idea that shared learning can simulate working relations is perhaps at its purest in the "Pride and Prejudice" courses (Marylebone Centre Trust, 1993). In Salford (Lucas and Davidson, 1995, 1e) aims for shared undergraduate studies were built upon twin pillars, first, to encourage teamwork and, second, to develop reflective practice. Objectives for the former included understanding roles and responsibilities in an organisational and managerial context, identifying the impact of social variables on health, illness and professional roles, and developing communication between practitioner and user and between practitioner and practitioner. The objective for the latter referred to developing skills in research and educational technology to support a problem solving strategy and project work.

Curriculum Content

In our earlier work (Barr, 1994a), we found that some initiatives stressed common curricula while others stressed interactive learning methods. We wanted to explore how far these relative emphases were borne out in the selected examples. Funnell included both in his list of qualities essential to effective shared learning (Funnell, 1994).

Several college-based examples listed subject areas deemed to be common to the learning needs of a number of professions. In one, common curricula for undergraduate chiropodists, occupational therapists and physiotherapists comprised information technology, health education and promotion, and communication skills (Lucas, 1990, 1e), with organisation and management added later (Davidson and Lucas, 1995, 1e). In another, for professions engaged in child protection, common curricula were research methods and findings, the law, and a range of theoretical perspectives (Stanford and Yelloly, 1994, 2h). Based upon the views of students and teachers from 13 qualifying courses in health and social care in Cardiff, Tope (1994) listed the following subjects as suitable for shared learning: psychology, sociology, law, ethics, research methods, economics of health, health promotion, quality control and assurance, and computing.

In some examples planners had clearly probed behind subject headings to test the relevance of content to the needs of each profession, although it was often harder to judge how common teaching had been applied to the particular practice of each profession.

While common content for college-based examples was typically expressed in the language of academic disciplines, that for work- based examples tended to be task related. Some concentrated upon the implementation of new legislation and policies, identifying similarities and differences in implications for each profession or service (Stevenson et al. 1993, 2f), others upon improving the effectiveness of practice (Cosier and Glennie, 1994, 2e), yet others upon improving community health provision (Thomas, 1994, 2c).

Finally, several initiatives focused upon common teaching methods. Bolden and Lewis (1990, 2k) saw experience in preparing GP trainers as applicable also to Practice Nurse trainers. The Joint Practice Teaching Initiative (Brown, 1993, 2l) sprang from the belief, first, that nurses, occupational therapists and social workers had common learning needs on becoming practice teachers and, second, that shared learning for practice teachers would lead to shared learning between their respective students. Similar beliefs were tested by research on behalf of the ENB (Wall, Clifford and Hicks, forthcoming) to evaluate situations where tutors for different branches of nursing are being prepared together.

While the Joint Practice Teaching Initiative pointed in the direction of shared practice learning, none of the examples brought to our attention put that to the test. Anderson and his colleagues (1992), however, explored the degree to which practice learning objectives for one profession (social work) could be met by a placement with another profession (psychiatric nursing). In the student's opinion, different professions employed different jargon to describe processes which were essentially the same. Much knowledge and skill, she said, was held in common, while differences lay in the working context, value orientation and goals.

The selected examples provide clear pointers for developing common curricula where learning needs are deemed to be the same or, at least, similar. The underlying assumption seems to be that rationalising the use of educational resources will, at the same time, provide common knowledge bases for collaborative practice. The examples revealed far less about comparative curricula, ie learning designed to highlight differences in powers and duties, roles and responsibilities, knowledge and skills and practice

contexts between the professions brought together. The onus was plainly upon participants to make such comparisons for themselves.

Learning Methods

Most of the examples were grounded in principles of adult learning. By applying those principles, participants were helped to value and utilise their personal and professional experience, and to learn from each other in a co-operative environment where competition was kept to the minimum.

Means to engender interactive learning were as imaginative as they were numerous. Exercises in self disclosure and conflict management, role plays and games were used to stimulate interaction and videos to trigger discussion (McMichael and Gilloran, 1984, 1b). Log diaries were kept and compared (Jones, 1986, 2a). Case studies were used (Woodhouse and Pengelly, 1992, 2j) to expose similarities and differences in values, perceptions and working practices, sometimes augmented by video presentations (Carpenter and Hewstone, forthcoming, 1c; Carpenter, forthcoming, 1d). Participants from different professions made joint presentations during seminars with their colleagues on topics of current concern.

Participants from different professions also made joint visits to patients and then joint presentations to the whole group (Jones, 1986, 2a; Carpenter and Hewstone, forthcoming, 1c; Carpenter, forthcoming, 1d), while some entering one profession were offered practice placements in the field of one of the others with whom they were sharing their learning as a means to further mutual understanding (McMichael and Gilloran 1984, 1b).

In one example (Shears et al. 1995, 2i) interactive learning also involved service users and their carers not only as participants, but also as planners, teachers, assessors and programme evaluators.

Teaching and learning strategies made extensive call upon Kolb's experiential learning cycle (Kolb, 1984). This, as sources helpfully summarised (Glennie and Cosier, 1994; Gorman, 1995), relates experience to observation and reflection, then to the formation of abstract concepts and generalisation, in preparation for further experiences.

Schon (1983 and 1987) had developed this view of practice learning and brought it into the arena of shared learning. References to his understanding of reflective learning and practice recur throughout many of the selected examples (Lucas, 1990 and Davidson and Lucas, 1995, 1d; Spratley and Pietroni, 1994, 2g; Cosier and Glennie, 1994, 2e) and elsewhere (Leathard, 1992; Westminster, 1994; Gorman, 1995).

Reflective practice encourages professionals to begin by observing real-life problems in all their messiness and confusion, followed by trained reflection and the application of theory. The significance of this approach for shared learning is that it lifts participants out of their respective fields of technical competence, inviting them to take a broader view, which calls upon powers of observation and methods of analysis which are equally unfamiliar, but equally applicable, to all. Each profession can then bring to bear that which is relevant and helpful from its experience and expertise. This last point is important. Schon, is not anti-technocratic. Rather he puts "technical rationality"

into a context which recognises its limits, while valuing artistry and intuition, and recognising the ambiguities within which professional judgements are made.

"Collaborative inquiry" owes much to the work of Kolb (1984) and Schon (1983 and 1987). Glennie and Cosier (1994) describe it as a method of action research which enables members of a peer group to explore their own practice, or a commonly agreed issue, in an iterative cycle of action, reflection, generalisation and planning. They see it as a process which empowers and develops participants' ability to understand, operate in, and modify their own working environment.

So its distinctive contribution lies in bringing cyclical learning into the work situation as a means by which practitioners can review their practice and work together to effect change. It lends itself to the inclusion of practitioners from different professions, thus enabling shared learning and collaborative practice to progress at the same time. Drawing upon the work of Reason (1988, 1989 and 1991), collaborative inquiry has been applied to shared learning by Nottingham University (Cosier and Glennie, 1994, 2e; Stevenson et al. 1993, 2f) and the Marylebone Centre Trust (Spratley and Pietroni, 1994, 2g).

Some readers may be surprised to find no reference to date to "problem-based learning", which WHO commended as the means to effect shared learning and Areskog (1994) has demonstrated so persuasively in his pioneering work in Sweden. Explicit reference to problem-based learning in the UK literature of shared learning is rare (but see Lucas, 1990, 1e; Davidson and Lucas, 1995, 1e), but, arguably, it is implicit in much of it. If, however, a generic term is needed, we, ourselves, would prefer action-based or work-based learning, which more comfortably encapsulates the range of methods being developed and avoids overtones which are occasionally perjorative.

Cyclical learning, reflective practice, collaborative inquiry and action at work-based learning all imply the acquisition of competence in collaboration by joint engagement in work related tasks. We were therefore on the look out for references to competency-based learning, but found nothing in the selected examples. That may hardly be surprising, given how recently that concept has begun to take hold in health and social care and the time lag in reporting shared learning initiatives.

Some leads can, however, be found from the wider literature. Hey et al. (1991) referred back to the knowledge, skills and attitudes which Kane (1976) held to be required by members of interprofessional teams, before inviting tutors (with some difficulty) to relate her formulation to the content of their interprofessional postqualifying courses.

Surveying outcomes from qualifying courses in social work, Whittington et al. (1994) invited recently qualified workers to comment, first, upon the importance of 13 skills in working with other organisations and professions and, second, upon the effectiveness of their courses in teaching them. These skills included networking, communicating, managing confidentiality and openness, forming co-operative relationships, negotiating and handling conflict. Respondents consistently rated them as "important" or "very important", but the perceived effectiveness of courses in providing them was uneven. The final report on this research is awaited. Arguably, embracing competency-based education is the only way in which shared learning can find an integral place within contemporary systems of vocational and professional education. However, to align

shared learning exclusively with competency-based education would be to risk alienating some of its supporters in higher education, where many teachers suspect a mechanistic and reductionist rationale which seems to them to leave little room for values, theories, judgements and discretion exercised by professionals (Barr, 1994b). These risks are at their greatest with reference to teachers in the more established professions, noticeably medicine. Nothing would be more unfortunate than to embrace uncritically a rationale gaining favour amongst the less established professions at the price of making shared learning with the more established even harder to achieve. Yet shared learning (itself no stranger to controversy) cannot hope to avoid such troubled waters for long.

Outcomes

Participants seemed to prefer practice-based and interactive learning to academic presentations (Carpenter and Hewstone, forthcoming, 1c), and learning in small rather than large groups (Gill and Ling, 1994, 1f). Residential courses had reportedly been especially valued for the opportunities which they afforded for social interaction in building lasting working relationships (Lambert, 1994). Non-assessed shared learning was liable to be valued less by participants with adverse effects on attendance (Lucas, 1990, 1e).

In one instance, criticisms were made that courses had not been joint enough (Brown, 1994, 1g), and there were also problems when co-teaching had fallen short as a collaborative model (Carpenter and Hewstone, forthcoming, 1c). Barriers and prejudices between teachers seemed to be more deeply held than between students (Jones, 1976, 2a; Lucas, 1990, 1e; Davidson and Lucas, 1995, 1e; see also Areskog, 1994b). Demands made of teachers in planning and delivering shared learning were heavy and sometimes exacerbated by complications in satisfying regulations and procedures for two validating bodies (Brown, 1994, 1g).

In one early initiative changes in participants' perceptions were the precise opposite of those sought (Jones, 1986, 2a). In other instances, improvements in perceptions were uneven or one-sided. Primary school teachers improved their perceptions of social workers and community workers, but those of social workers towards the teachers worsened (McMichael and Gilloran, 1984, 1b). Similarly, one profession was sometimes more satisfied than another, nurses more than doctors (Carpenter, forthcoming, 1d), and social workers more than doctors (Carpenter and Hewstone, forthcoming, 1c), but in spite of criticisms during shared learning, positive outcomes may still follow (Spratley, 1990b, 2b).

Testing changes in perception five months after the end of the initiative, Shaw (1994, 2d) found that improvements during the initiative were reversed subsequently. This pointed to the need to relate outcomes from college-based shared learning to the climate for collaboration in the workplace.

James (1994) and James and Tucker (1994) reported on a follow-up survey of students who had completed a two-year shared masters course in the care of elderly people. While participants had valued their experience, they had needed enlightened management to be able to make use of their new-found knowledge. Some reported

frustration at colleagues' lack of receptiveness to new ideas, such problems being most acute in hospitals. Some had reportedly been passed over for promotion in favour of less qualified and less experienced colleagues. Were these cautionary findings peculiar to one local situation (in Hull) or indicative of wider worries which had hitherto escaped attention in the literature?

Work-based opportunities to review current practice were said to be valued (Spratley, 1990a, 2b). Whereas the impact of college- based shared learning cannot easily be gauged (given the intervening variables), that of work-based shared learning was sometimes more immediate and measurable (Thomas, 1994, 2c).

Where outcomes were disappointing, the typical reaction was to review content and methods critically (Jones, 1986, 2a), or to argue that more time should be allocated to shared learning (McMichael and Gilloran, 1994, 1b). So efforts were to be redoubled, while underlying faith in the efficacy of shared learning was undiminished.

SELECTED EXAMPLES

1. BEFORE QUALIFICATION

1a.
General Practitioners, Health Visitors and Social Workers during Practice Learning

Unencumbered by past relations, health and social care professionals in the new dormitory town of Thamesmead south east of London were intent upon establishing positive working relations. A social work student unit had been established linked with primary health care. It was around this that ideas for an interdisciplinary project grew.

The "de facto" aims were: to provide an interdisciplinary training programme for students on placement in Thamesmead; to create opportunities for workers in Thamesmead to develop their understanding of common problems; and to provide a climate for interdisciplinary work in Thamesmead.

Jacques (1986) reported mainly upon ways in which the first of these aims took hold. The idea was that student doctors, health visitors and social workers, coincidentally doing their practice learning in Thamesmead, might share learning experiences. The doctors came from Guy's Hospital Medical School, the health visitors from Croydon College and South Bank Polytechnic, and the social workers from a wide range of courses.

A succession of meetings were convened between 1976 and 1979. Participants came together in many and varied ways. Sequences of lunch time gatherings were the most common, but there were also half day workshops and a weekend retreat. The organisers wanted to experiment with different patterns.

They also wanted to experiment with different ways of interpreting the "experiential cycle" as subsequently formulated by Kolb (1979). Straight information giving was ruled out. "Ice breakers" were used, for example, students' interviewing one another in pairs, each then introducing the other to the group. Games were played – "the Health Centre Game" and "the Urban Aid Game". Exercises were devised in sentence completion, for example, "My problem with general practitioners/health visitors/social workers is ——". Comments recorded were then fed into group discussion. There were also role plays, case discussions, joint home visits, joint supervision sessions, peer teaching and topic groups, while action projects set up a community group and planned a workshop.

Evaluation was based upon participant observation, students' diaries, trainers' notes and interviews. Use of semantic differentials and repertory grids proved to be unpopular and was discontinued. Findings referred mainly to students' satisfaction with each

initiative, criticism being strongest where one profession proved to be a poor attender, and to some extent of reciprocal perceptions. Generalisations were wisely avoided, given the diversity of the activities.

1b.
Community Workers, School Teachers and Social Workers

Staff at Moray House, Edinburgh, wanted to overcome the barriers between the three professions taught on its qualifying courses: community workers, primary school teachers and social workers. Incomprehension and even hostility often characterised relationships between them. While such behaviour could be explained in interpersonal, intergroup, organisational and cultural terms, it had also be to be acknowledged that processes of differentiation, which served valuable functions in creating and maintaining individual and group esteem, exacerbated these problems. As a result, value differences found when the three groups arrived in College, if anything, increased by the time they left. By intervening during the early stages of training, staff hoped to obviate some of the difficulties which arose subsequently in practice (McMichael and Gilloran, 1984).

They began by testing their assumptions about initial differences between the three groups by means of questionnaires, observation and interviews. These confirmed that student community and social workers had less positive memories of their earlier education than did student teachers, and approached learning in College differently. Teaching encouraged the former to respond flexibly to social change, but the latter to ensure social conformity and stability. Given this divergence, how could the College intervene to engender collaboration in resolving individual and community problems?

For guidance, staff turned to perspectives from social psychology (Berkowitz, 1975, Tajfel, 1981 and others). Trying to modify attitudes (and associated knowledge) was seen to be the one part which the College could play. It should attempt to bypass the need for stereotyping as the means by which the student groups defined one another. Furthermore, by developing contact and identifying similarities in attitude, liking should follow, mutual approval might reinforce self-esteem, and anxiety be reduced.

Three shared learning programmes were put to the test, with different students involved in each. The first offered placements to student teachers in a community or social work setting, and to student community and social workers in schools. This programme was not evaluated.

The second programme was a common course in social psychology organised around small and large groups. Workshops offered opportunities for interaction between the three groups. Each workshop required students to complete a questionnaire, repertory grid or a rating scale, thereby exposing their thoughts to each other. They discussed ethical issues. They competed in games. They engaged in role play.

Comparing responses to questionnaires before and after this programme found that student teachers were more favourably disposed to the student community and social workers than vice versa. Indeed, attitudes of student community and social workers towards student teachers after the joint course tended to be more negative than they were before. Changes towards more positive attitudes between the groups affected

less than a quarter of all the students. Looking for explanations, the teachers thought that an hour and half per week over two terms had been insufficient, numbers had been too big (146 in total) and unevenly distributed between the groups. Furthermore, some staff had hesitated to force the groups to mix and, as a result, some students had stayed in their own cliques.

The third programme comprised a series of workshops. A total of 177 students took part. Tutorial groups of eight or nine each comprised four students from teaching, two or three from social work and two from community work. Five two hour meetings included discussion of a video on communication problems, a case study, determining professional priorities, a do-it-yourself collaborative project, and the management of conflict based upon a videoed incident.

Again, before and after comparisons suggested that student teachers had gained most. They showed greater awareness of how social workers could assist them in their work, but this did not extend to community workers. For their part, student community workers and social workers remained critical of primary education, but more aware of some of teachers' frustrations.

McMichael, Molleson and Gilloran (1984) collated materials from these and other workshops, while Michael, Irvine and Gilloran (1984) provided a detailed account of the research methodology.

1c.

Doctors and Social Workers

Carpenter and Hewstone (forthcoming) reported on shared learning for social work and medical students in the final years of their qualifying studies in the University of Bristol. The programme was designed in the light of social psychological studies of intergroup behaviour (the Contact Hypothesis) in which participants worked as equals in pairs and small groups on shared tasks in a co-operative atmosphere. Participants' profesional identities were emphasised throughout and there was a focus upon differences as well as similarities.

The first "effort" involved pairs of social work and medical students jointly interviewing psychiatric in-patients, followed by joint presentations to a small discussion group which was co-led by a psychiatrist and a social worker from the hospital. These group leaders drew out similarities and differences in the attitudes and skills of the two professions to highlight their respective roles and duties, and to show how they might work together in developing a plan of medical and social care for the patient. Students reportedly found this more motivating, more challenging and more productive than theoretical discussion, although potential hazards arose where students differed in knowledge and confidence, or the tutors provided unequal contributions or demonstrated an inability to work with each other.

Going beyond this modest beginning, the equivalent of one week of shared learning was built into final year studies for medical and social work students from 1986. Shared learning was compulsory for both groups, but not assessed. An evaluation was made of the experience of one cohort of 85 participants, 41 were from medical

students and 44 from social work. It proved to be impractical to have a control group.

At separate introductory sessions, the participants were given some information about one another asked to sign up for two and a half days of shared learning events. Day events usually involved practical exercises in the field (on the model of the earlier initiative). Half day events were usually classroom-based, often using video case studies. Topics included: alcohol abuse; psychiatric emergencies; AIDS/HIV; depression in young families; deliberate self-harm; drug abuse; and community- based services for people with learning disabilities. Each event was led by a doctor and a social worker. Echoing the previous initiative, the objectives for each event were: to examine similarities and differences in attitudes and skills; to acquire knowledge of respective roles and duties; and to explore methods of working together. Students worked in pairs and groups, members being expected to stay in their respective professional roles. Group leaders were asked to draw attention to differences as well as similarities and to provide positive feedback.

Evaluation took account of participants' perceptions of the programme and changes in attitude. Before meeting the other group, participants completed a questionnaire using a seven point scale to rate perceptions of the programme, attitudes to their own group and to the other group, knowledge of the latter's attitudes, skills, and difference between the two groups. On completion of the programme, a second questionnaire repeated the questions about the other group and about similarities and differences. In addition, they were asked to rate the success of the programme for enjoyment, co-operation/competition, and the degree of equality achieved.

Before and after data were compared using an analysis of variants. Some participants recorded initial apprehension and misgivings about the programme, although social work students were significantly more positive than medical students. Each group was more positive about itself than about the other.

However, by the end of the programme overall attitudes towards the other group had become significantly more positive, while those towards their own group remained constant. Self-rating suggested a small but significant increase in knowledge by each group about the attitudes, roles and duties of the other. Both groups believed that they had worked as equals, but the doctors were more convinced. Both evaluated the programme positively with social workers judging it to be more useful than doctors.

Carpenter and Hewstone concluded that the programme had been largely successful in meeting its objectives, although measured changes were "not huge" with considerable individual variations. Compulsory attendance was thought to account for resentment amongst some doctors, some of whom felt trapped into an experience which was biassed against them.

A related paper (Hewstone et al. 1994) described these initiatives in their theoretical framework, with extensive references to the literature of social psychology. The "contact hypothesis" was acknowledged to be a truism, namely that association with a disliked group can, under favourable conditions lead to a growth in liking and respect. Hewstone and his colleagues concluded that there was strong evidence to support the thesis that the design features of the programme had created conditions for positive attitude change.

1d.

Doctors and Nurses

Carpenter (forthcoming) reported on a similar initiative between final year medical students and fourth year undergraduate nursing students. The experience of one cohort of 39 students (23 from medicine and 16 from nursing) was evaluated. The doctors were from the University of Bristol, the nurses from the then Bristol Polytechnic (now the University of the West of England). Division between the two institutions added to the logistical complications in organising shared learning. The programme was optional for the doctors, but compulsory for the nurses.

The students met in workshops for one day per week. One workshop, for example, looked at communications between doctors, nurses and patients. This was based upon a videoed case study, the issue being what the patient should be told about the prognosis following a diagnosis of bowel cancer. Interprofessional pairs discussed good and bad aspects of the practice observed and selected pairs reported back to the whole group. Small groups then discussed the issues arising.

Evaluation followed the same pattern as for the initiative between doctors and social workers. Before the start of the programme doctors and nurses were only mildly positive about its usefulness and contact with each other, but neither group indicated apprehension. Both rated the status of doctors highly and of nurses much lower.

Attitudes towards the other professional group changed for the better during the programme, but more so on the part of nurses towards doctors than doctors towards nurses. In each case, attitudes towards their own professional group remained constant. In a companion paper, Carpenter (1995) shows that there had been a significant changes in negative stereotyping. For example, the nurses saw the doctors as less detached, more caring, less arrogant and better communicators.

Nurses' knowledge of doctors' roles and duties increased significantly, whilst doctors' knowledge of nurses' roles and duties remained constant. Overall, the programme seemed to have been more successful with nurses (who were younger and less experienced) than with doctors.

Both groups judged the programme to have been a success, had found the atmosphere co-operative, and felt that they had worked as equals. Each had experienced the attitudes of the other as positive, but the nurses were more convinced of this than the doctors.

In conclusion, Carpenter made some comparisons between the evaluations of the shared learning between doctors and social workers, on the one hand, and doctors and nurses, on the other hand. In the former, it was the doctors whose attitudes had changed most, but in the latter it was those of the nurses. While allowing for variations in the duration, form and content of the programmes, the main difference was thought to lie in the less hostile and entrenched relationships between doctors and nurses than between doctors and social workers. Doctors had, however, improved their ratings of social workers' academic quality during the programme, but not of nurses.

The two programmes demonstrated, said Carpenter, how attitudes can be changed and knowledge increased between professions as a result of interprofessional education.

Such change was surely a necessary condition for co-operation in practice, but barriers to co-operation were structural as well as educational and attitudinal.

The programmes reported here were two of several in Bristol which had brought together students (typically pairing two professions) from medicine, social work, probation, teaching, community psychiatric nursing, health visiting and district nursing.

1e.

Professions Allied to Medicine

Lucas (1990) described initiatives at University College, Salford, to introduce shared learning into qualifying courses for occupational therapists, physiotherapists, radiographers and chiropodists.

NHS Training Managers (1986) had identified skills, methods and learning needs common to the professions allied to medicine (PAMs) and best met by core training, but respective territory had been jealously guarded. Shared learning prior to making a career choice could be a powerful influence in workforce planning, while moves to amalgamate paramedical schools and to establish schools of health studies would be encouraged. Conversely, formation of the first such schools was creating conditions favourable to shared learning and exerting pressures to rationalise courses. Falling numbers on courses reinforced the need to obtain economies of scale.

The first moves towards shared learning at Salford came in 1985. Priority was given to changing attitudes within the College by means of staff development. A post registration, part-time honours degree was introduced and made available to college tutors and to clinical tutors and clinical supervisors from health authorities. Based upon a comprehensive needs analysis, a modular programme was designed around four themes: community care, management and training, rehabilitation studies and health research. The course was heavily over-subscribed. The first cohort of 76 comprised 12 physiotherapists, 29 occupational therapists, 18 chiropodists, 11 radiographers, two orthoptists, one dentist, one nurse and one community health worker. As recorded in follow-up questionnaires, 78% of the cohort found the course enjoyable, 69% thought that it had informed them about other professional roles and responsibilities and 75% supported the philosophy of shared learning in pre-registration courses. Subjects thought by students to be appropriate for such shared learning were: methods of enquiry, information technology, communication skills, organisation and management, basic psychology, health education and promotion, basic sociology, basic anatomy and basic physiology.

The views of pre-registration students were then canvassed. Only 21% said that they were committed to their chosen profession on day one of their course and 54% would have preferred a shared core curriculum and multidisciplinary work experience before making their career choice. These results had to be set alongside high course wastage. Two initiatives followed.

First, four students each from chiropody, occupational therapy, physiotherapy and radiography came together for a half day programme built around presentations about the role of each profession, multidisciplinary case studies and an open forum. At the outset, students identified their perceptions of the role of each of the other professions

in a questionnaire. This was repeated at the end. Replies revealed how perceptions had been broadened.

Second, final year diploma students in chiropody, occupational therapy and physiotherapy shared studies in information technology, health education and promotion, and communication skills. This was a pilot project before introducing shared learning into a new paramedical degree programme.

Discussions with the diploma students revealed that they had not given it priority as there had been no assessment. In consequence, attendance had been poor. Most felt that they had been insufficiently inducted into the purpose of shared learning. They had welcomed meeting students on other courses, but had wanted more time together to learn about respective roles and responsibilities. Some students criticised their teachers for not practising what they preached.

Davidson and Lucas (1995) described subsequent developments within the degree programme. Shared learning had been introduced to encourage teambuilding and to develop reflective practice. Objectives for teambuilding were: to understand roles and responsibilities of health care practitioners and the organisation and management of health services within which they worked; to identify the impact of social variables on patterns of health and illness and relate them to health practitioner roles, including that of health educator, and to develop effective and efficient communication and cooperation between practitioners and client, and practitioner and practitioner. The objective for reflective practice was to develop skills of analysis and synthesis through research methods and information technology to support problem solving teaching strategy and project work.

Shared learning was organised in modules during four, six-week blocks throughout the three years. Modules covered communication skills, information technology, sociology of health and illness, methods of enquiry, health education and promotion, and organisation and management.

A total of 530 students participated in shared learning, in classes averaging 35. Such learning represented 9.4% of the degree programme, assessments carrying 36 out of the 360 credits necessary for the award.

At the time of going to press, said Davidson and Lucas (1995), their School had mixed feelings about multiprofessional education. Discussions were back at the crossroads with questions about whether MPE should be a significant feature within professional programmes.

1f.

Branches of Nursing

In 1991 Suffolk College introduced shared learning for health visitors, district nurses and occupational health nurses into courses leading to a Diploma in Higher Education in Professional Studies. As Gill and Ling (1994) observed, this mix of groups may be regarded as intraprofessional rather than interprofessional, but provides insights which may apply beyond the boundaries of these nursing groups.

The impetus came, nationally, from moves to amalgamate existing nursing specialisms and to up-grade nurse education to DipHE or degree level, and, locally, from the need for "community practitioners" who would be responsive to changing user and service needs. Furthermore, the College was in the process of modularising its higher education provision.

A total of 61 students formed the first cohort (15 district nurses, 23 health visitors and 23 occupational health nurses) and provided the subjects for the research. Common foundation studies were provided for all three professions, in mixed groups. Specialist studies remained separate as did practice placements. However, "integrated studies" used "joint working teams" from the three professions to present seminars on issues of mutual concern.

Research was built in to discover how students viewed shared learning in prospect, to identify events or process during the course which enhanced or detracted from the experience, and to identify productive and counter-productive strategies within the programme as a whole. Questionnaires were administered to students before the course, following an induction period, at the end of the common foundation studies and integrated studies, and on completion of the course. Some questions were repeated. Response rates declined for each succeeding questionnaire.

Knowledge that the course would be shared had reportedly been influential in the decision to apply for just 3% of the students, a further 77% regarding this as attractive, but not critical to their decision. However, perceptions of shared learning differed. For 56% it was "learning the same knowledge alongside other professions" for 24% "learning interactively from other professionals".

Views on the value of shared learning were sought at the outset. For 31 % this lay in increased stimulation and knowledge, for 26% improved working relations and for 25% understanding others' roles. By the end of the course, 48% said that the value had been understanding others' roles, 19% improving working relations, and 9% increased stimulation and knowledge, with other answers being improving communication, understanding organisational structure and sharing attitudes. For 7%, however, shared learning was reportedly of no value.

The main barriers to shared learning identified by students were the structure and management of the course (34%) and the (large) size of the group (33%). Other barriers were insufficient shared knowledge or activities, understanding of roles and personal contact. Despite these barriers, 85% indicated a belief in a common purpose for their three professional specialties. Health promotion, interpersonal skills and communication were identified as areas of overlap.

Commenting upon each of the main course components, 70% thought that sharing foundation studies had been beneficial, with 96% regarding the integrating module as beneficial. Significantly, perhaps, the latter involved work in small groups with increased communication and interaction.

Asked at the end of the course whether shared learning had prepared them for working together, none of the students thought that they had been prepared "very well", 34% "adequately", and 66% "a little".

1g.

Nurses and Social Care Workers in Learning Disabilities

John Brown (1994) was commissioned to review two initiatives in shared learning for nurses and social care workers in the field of learning disabilities, one in North East London and Essex, the other in South East London and Kent. Both entailed stretching Certificate in Social Service (CSS) "schemes" to include staff from long-stay hospitals which were destined for closure.

Unlike other initiatives, where only a small proportion of students' time was shared during their respective qualifying courses, the ENB and CCETSW had approved a pattern where the complete programme was to be shared for the first two years. At that point, students specialising in work with people with learning disabilities would be eligible, subject to satisfactory progress, for the award of the CSS (like their fellow students following other specialist pathways of study). They would, however, have the option to proceed to a further year's study to satisfy ENB requirements to gain the RNMH. (There was no comparable topping up for other specialist fields.)

Brown drew upon internal evaluation of each programme. He also interviewed 82 representatives of social services departments, health authorities, colleges and validating bodies to find out how this highly ambitious and original programme had worked out. Insufficient time, he said, had been committed to planning by both parties. Collaboration had been bedeviled by differences in culture, regulations, procedures, management structures, styles of decision making and committee cycles. Much time had been spent in airing and working through professional prejudices and misunderstandings. Two separate training courses had to be wedded, not welded, together. Neither initiative was truly joint and social services departments were unwilling to release their staff. Brown attributed this to low priority accorded to staff working with mentally handicapped people, but account had also to be taken of the added cost of an additional year on the normal CSS course.

Of 11 students starting the joint training in Essex in 1988, six dropped out and only two of the remaining five returned to the health authority on completing their courses. The situation for the first cohort in Kent "was not so dire", but some students failed to complete on time.

In spite of difficulties and setbacks, employers welcomed the provision of a broader skills base and the links forged between agencies. Problems for employers lay in the time needed for student supervision and to arrange placements and the extended length of the course. Joint training was seen by some employers as less competency-based than the RNMH, too theoretical, and out of tune with NVQ developments. There was a risk that returning students would be over qualified. This heightened the danger that some would not return to the health authority on completion of their courses. Ways of deploying these CSS/RNMH holders appeared not to have been sufficiently considered. Even so, employers thought that staff might be promoted more quickly.

Students complained that courses were not joint enough. The difference in "philosophy" between nursing and social work had been a "culture shock". Especially in Essex, students had had to cope with two different sets of teaching styles, placement requirements, and assessment models.

Teachers had also found differences in philosophy and teaching styles disjointed. Workloads for nurse teachers had increased, not least because of the demands of study supervision and finding local authority placements. Yet they regretted the impending end to the initiatives as new training systems for nursing (Project 2000) and social work (the Diploma in Social Work) came on stream.

Further pilot programmes were, however, launched subsequently at South Bank University, London, and Portsmouth University in partnership with health and local authorities. These explored scope for shared learning between undergraduates preparing for the Diploma in Social Work and to qualify as nurses within the framework of Project 2000, preparing to work with people with learning disabilities.

SELECTED EXAMPLES

2. AFTER QUALIFICATION

2a.

Team Development in Primary Health Care in Devon

The earliest of many initiatives in Exeter (Jones, 1986) was in response to both national and local concerns. Nationally, there was growing interest in shared learning (CETHV, 1976 and 1979; England, 1980; RCGP et al,1983) as the workforce in primary health care became more diverse and professional roles more diffuse. Locally, there was an absence of shared learning for health and social work practitioners.

A Community Training Liaison Group was convened by Exeter University's Department of General Practice, comprising teachers of postgraduate nursing, social work, general practice and, later, health visiting and therapy. Its remit was to increase understanding amongst trainers of the tasks and problems of comparable professions, to explore possibilities for co-operation in training and for pooling resources, and to assess the benefits of such co-operation.

"Novice days" were mounted from 1978 to 1985 for community-based workers. Initially these were nurses, therapists, social workers and trainee general practitioners, four or five participants being involved from each profession. The aim was "to increase appreciation of the roles played by other members of the caring professions working in the community". Each day was evaluated by means of before and after questionnaires.

The first of these days was in a medical setting and built around "log diaries". Outcomes were said to be the exact opposite of those hoped for by the organisers. The confidence expressed by the nurses, therapists and social workers in the doctors' ability to do everything apparently increased, while the doctors had less confidence in the others being able to do anything.

This prompted a searching reappraisal. For the second year the venue was moved from a medical to a nurse setting, more experienced workers were recruited from social work and therapy, and trainee health visitors added. The log diaries were withdrawn from the programme. Instead, each profession made presentations about itself to the others in twos and threes, the listener(s) then reporting back to the big group. Observation followed of a case conference and, finally, there was a discussion about barriers to co-operation.

The initial exercise reportedly produced an animated response which carried through into the afternoon, even though the intervening observational session had been more subdued. Feedback suggested that the roles and skills of social workers were better appreciated by doctors, health visitors and therapists, those of nurses were better appreciated by doctors, and those of health visitors were better appreciated by social workers.

The programme continued to evolve year by year. Work in small groups was maximised. Home visits were made to patients/clients by multidisciplinary "teams". These were followed by discussion, first with the practitioner responsible for that case, then in plenary session. This was deemed to be the most successful format and was repeated, with equally positive results.

After running four annual novice days, an overnight symposium was mounted for 30 teachers to stimulate an increase in interdisciplinary learning in the region. Equal numbers of teachers were invited from general practice, social work, community nursing and therapy. Work in small groups was interspersed by lectures. While much the same lessons were learned as during the novice days, the organisers formed the impression that initial barriers took longer to disappear, and prejudices were more deeply held, amongst teachers than novices.

2b.

Health Education in Primary Health Care

While promoting teamwork, per se, provided much of the early impetus for shared learning in primary health care, promoting health education came to be a major vehicle through which to foster common commitment and collaborative working between team members. The series of workshops reported here constituted, according to Beattie (1994b), the last of three phases in promoting health education. The first was the development from the late 1970s of postgraduate courses in polytechnics for intending health education officers drawn from a range of professional backgrounds, and university-based masters courses to prepare for positions of leadership in health education. The second phase brought health education into the mainstream of education for health professions within existing courses, with the intention of helping students to promote health education in their own jobs, not to become health education officers. The third phase was "team-oriented", starting with isolated initiatives, but gathering momentum as a major thrust in health promotion within primary health care. Spratley (1990a and 1990b) described its progress and outcomes. Her work is called upon here as she was the designated researcher responsible for evaluation, in preference to that of Lambert (1988, 1991 and 1994) as one of the key actors.

Spratley (1990a) reported on 18 workshops run by the Health Education Authority (HEA) for primary health care teams throughout England. The number of participants ranged from 14 to 43. A minimum of three came as colleagues from each primary health care team taking part. They included general practitioners and their trainees, nurses, health visitors, practice managers, administrators, secretaries and others. In all, 521 primary health care professionals took part from 122 teams.

Workshops lasted two days. Fifteen were residential with the days consecutive, the remaining three non-residential with the days separated. The aim was to encourage and stimulate participation in prevention and health promotion that could readily be undertaken within or alongside general practice.

Based upon principles of adult learning, the workshops valued and utilized knowledge and skills which participants brought from their experience. Learning was facilitative,

participative, collaborative, reflective and exploratory, rather than didactic, while problem solving was used to encourage and develop teamwork. The earliest of these workshops were built around the Open University learning pack, "Coronary Heart Disease – Reducing the Risk". Preventing cardiac arrest continued to be the most common theme, but other workshops tackled themes such as alcohol, child health and the care of the elderly.

Teams were helped to establish their baseline, to locate target audiences, to identify inhibiting and facilitating factors, and to devise means of evaluation. Follow-up meetings reinforced implementation and provided opportunities for feedback.

Evaluation compared development, implementation and management of the workshops with the overall aims. This involved Spratley in analysing reports, digesting findings from questionnaires, observing planning meetings, participating in pre-workshop meetings, and taking part in de-briefing and follow-up meetings. She concluded that the workshops had provided a robust and flexible framework for the development of prevention and health promotion in primary health care. Participants had appreciated opportunities to review practice and make plans. Communication, teamwork and organisation had improved, while roles and responsibilities had been clarified.

In a second report, Spratley (1990b) reviewed the effectiveness of nine workshops for "Local Organising Teams" (LOTs) and subsequent workshops for primary health care teams run by LOTs.

LOTs comprised senior personnel from key health agencies such as regional and district health authorities and family health service authorities, who were well placed to support developments in prevention and health promotion in primary health care. They were not normally working together in teams, but developing teamwork was nevertheless an important part of these workshops.

Workshops lasted three days. All but one were residential. Their aim was to activate a self-sustaining programme of workshops for primary health care teams with support from Family Practice Committees and District Health Authorities. Content included information giving, group work and presentation of plans. Evaluation was based upon quantitative analysis, individual and group interviews, documentary analysis and participant observation. Findings were more problematic than for the PHCT workshops. Participants were uncertain as to the purpose of the workshops and their own roles, with "delegated" staff doubtful about whether they could deliver what was being expected of them. Orientation towards primary health and health promotion differed, while scepticism was encountered regarding the effectiveness of approaches to health promotion.

Nevertheless, groups were formed to plan PHCT workshops in most regions where LOT workshops had been held. Themes for the former ran wider than for the earlier workshops mounted by HEA itself. They included: management systems, computerisation, audit and evaluation, patient education, care of the elderly, child health, adolescent health, linking with ethnic minority groups, post- coronary support, amongst others.

In spite of misgivings during the LOT workshops, PHCT participants at workshops run subsequently reported positively upon their value. A further outcome was support from HEA to establish the National Facilitator Development Project in Oxford at the HEA

Primary Health Care Unit to provide a continuing resource for preventive work with PHCTs. In 1993, the HEA brought together participants from RHAs, LOTs, PHCTs, Social Services and the HEA Primary Health Care Unit to share experience and to generate ideas. They agreed that PHCT workshops provided protected time to reflect and concentrate upon specific practice issues, to learn within and between teams, and across sectors. Less positively, they concluded that residential workshops (for as many as five participants from each team) were expensive and attracted inadequate financial backing locally or nationally. Facilitation skills were also said to be lacking in some LOTs. One solution was to involve freelance facilitators or those from the HEA Primary Health Care Unit, but this added still further to the expense.

2c.

Team Development in Primary Health Care in Liverpool

Some areas established their own resource units. Thomas (1994) reported upon five years' of developmental work in Liverpool. During the first stage (1989 to 1991), two facilitators – a GP and a nurse – worked with GPs and practice nurses throughout the city to break down isolation, to promote the employment of practice nurses and to encourage a reorientation from the isolated treatment of disease towards participation in health. A plethora of activities followed. Innumerable meetings were held to look at clinical, contractual and organisational issues and to float new ideas. "The Liverpool Health Diary" was published to provide GPs and nurses with health information and a directory of resources. Six mentors were appointed to support the rapidly growing number of practice nurses, reinforced by courses at Liverpool University. Patients were interviewed in waiting rooms about health hazards at work and, in one project, even offered daffodils in exchange for cigarettes! In the second stage (1991 to 1994), an enlarged team of facilitators comprised a GP, a health visitor, a practice nurse, and a practice manager. The target group was also widened to include GPs, health visitors, practice nurses, receptionists, practice managers and district nurses and, so far as possible, schools, the voluntary sector and community groups. Priorities were to develop more effective and efficient teamwork, skills to learn from others and from daily work, skills to convert information into prompt action, and models of collaboration. Different initiatives were tested and refined. "Multi- disciplinary forums" explored current health issues and new ideas. "Multi-disciplinary workshops" examined specific problems and instigated action. "Road shows" subjected a chosen aspect of a practice's work to audit. "Residential teambuilding workshops" shared visions and problems and formulated objectives. These and other initiatives helped staff to learn how to participate in groups.

Tangible benefits resulted. Data for childhood immunisation, pre- school immunisation, and cervical cytology for the 28 practices in the "Facilitation Project Target Area" (27% of practices in the city) were consistently better than for practices in the city as a whole. However, the underlying cultural change cannot, as Thomas observed, be measured solely in quantitative terms.

2d.

The Open University and Learning Disabilities

Shaw (1994) tested a number of ways to evaluate the impact of a distance learning course about learning disabilities (Open University P555) used for combined groups across health and social care. The course aims included promoting changes in the students and thereby in the lives of people with learning disabilities, and collaboration between interested groups such as parents and various professions for whom the course was intended.

Data were collected from course participants and matched control groups. Questionnaires were administered by interview before, immediately after and five months after the course to measure changes in attitudes towards the client group and in understanding of others caring for that group. An attitude scale was constructed using the concept of semantic differentials. Respondents were asked to grade client behaviour from "good" to "bad". Repertory grid technique was chosen to explore perceptions of professional roles using personal constructs.

Comparing perceptions before and immediately after the courses, Shaw found positive and significant changes by participants in the direction of understanding other carers compared with the control groups. Five months later, however, that difference had largely disappeared. He attributed this to lack of support for collaborative working. Once the support of the course had been removed, it seemed, staff had amended their perceptions to conform to working reality. Shaw concluded that the role of the line manager was critical in creating a climate of change.

2e.

Collaborative Inquiry in Child Protection

Northamptonshire Social Services Department commissioned two "collaborative inquiries" from the Professional Development Group at the University of Nottingham. One investigated supervision in child protection (Cosier and Glennie, 1994), the other contributed to an evaluation of the impact of four pilot projects which had been designed to deliver a care management service to elderly people in the community (Stevenson, Firth and Glennie, 1993).

The child protection inquiry started from the premise that ownership was a key ingredient in catalysing change. Individuals and groups needed to be empowered by active participation to explore options on the basis of their own knowledge of a situation. The need for effective supervision for professionals working in child protection in Northamptonshire was acknowledged, but little was known about how it was being met. A group of eleven first line managers was convened to investigate this. They represented education, health, NSPCC, police, probation and social services. After protracted preliminary negotiations, the group met on seven occasions over four months. Baroque guitar music greeted participants as coffee was served before the first meeting; every effort was made to put them at their ease. Priority was given during that meeting to getting to know each other. Each participant interviewed another from a different agency and introduced him or her to the group. Small groups then addressed

the question "What can we contribute to the Inquiry and what do we want from it?" Finally, a plenary session discussed common features of management and supervision. Discussion ranged from the particular to the general.

An "Inquiry Map" was devised for subsequent sessions to set limits and give direction. It incorporated three phases in the groups experience, "ascent" (exploration of supervision as a topic), "flight" (understanding the task of supervision in context) and "descent" (relating what had been learned to current supervisory practice).

Outcomes concentrated the desirable and the achievable. Attention was paid to specialist characteristics of management and supervision in child protection, the need for role clarity between agencies, and issues affecting cross-agencies communication and co-operation. The Inquiry ended with a formal presentation to the Area Child Protection Committee (ACPC). Reflecting upon the experience of the group, Cosier and Glennie were in no doubt that it had been of value to participants, who had enjoyed learning from one another, while barriers had been dramatically lowered.

2f.

Collaborative Inquiry in the Care of Elderly People

Reporting on the second of the two inquiries in Northamptonshire, Stevenson et al. (1993), addressed the need for new working alliances to implement new policies for community care. Uncertainty had to be tolerated while additional knowledge was acquired and new understanding developed. Change had to be induced, not imposed. Collaborative inquiry offered one way to do this.

The Inquiry involved a multiprofessional group who had been practising together for a year. For three months they became researchers, followed by a further six months' working together in the group. Their task was to consider the impact of different care management structures in four pilot areas, to explore the shifts in knowledge, skills and attitudes which each of those structures required, and to elicit the perceptions of key professionals in those areas regarding the impact of care management on their roles and on service delivery.

The facilitators made preliminary visits to each pilot area to introduce the idea of Collaborative Inquiry and to acquire first hand impressions of the issues. Care managers were, it seemed, operating in a hostile environment. Some social workers were reluctant to refer existing cases to care managers for assessment, while progress had been slow in forging links with local GPs. Care managers felt professionally isolated and in need of more support.

Open meetings followed at County level with service users and their carers, health and social service purchasers and providers, independent home owners and the voluntary sector. Apprehension was evident about changes afoot. Fears were voiced that pilot projects were painting "a rosy picture" in areas where interprofessional relations were known to be sound. There was concern about how care managers would gain access to health resources, about the isolation of GPs and consultants and the marginalising of the Housing Department. The voluntary sector worried about the adjustments which might be required to fulfil contracts, while independent home owners feared undercutting

as local authorities were forced to purchase the cheapest care. User and carers shared their problems in accessing information, but had found having one point of contact less confusing.

It was against this backdrop that the Inquiry Group was convened. Its task was to define the role of care manager, to identify knowledge, skill and attitudes/qualities required for that role, to encourage "practice sensitivity" and identify critical factors in the environment. Particular attention was paid in its report to ways in which care managers established different kinds of relationships with the Social Services Department and outside, include models for joint assessment.

2g.

Collaborative Inquiry in Primary Health and Community Care

During 1992, the Marylebone Centre Trust included 24 workers from primary health and community care in one of two workshops with the object of enlisting their help in identifying learning priorities (Spratley and Pietroni, 1994).

Participants were drawn from social services, health services, carer organisations, the voluntary sector and educational institutions. They were invited to present examples of current projects which involved a high degree of collaboration across professions and organisations. They were then asked to identify what had helped and what had hindered collaboration, and to consider the implications for interprofessional education and training. Each workshop lasted for a day with a half day for follow-up. Each had three staff members – facilitator, rapporteur and observer. The facilitator managed the workshop, while the rapporteur recorded the group work and the observer took a relatively non-participant role, but provided some feedback on process.

The workshops were structured to follow an action and reflection cycle. Action on the day took the form of presentations made by a total of 12 participants. Topics ranged from open referral in community mental health to meeting the needs of long-term housebound people and from working with carers of people with learning difficulties to a multidisciplinary approach to health promotion. Reflection took four forms: small group discussion, the rapporteur's records, feedback from the observer and reporting back to the large group.

Issues discussed were: the impact of policy and organisational change upon professional roles; the impact of basic professional education and the place of interprofessional education; professional differences as difficulty and opportunity; difference in language, culture and values; collaboration with carers; user-centred services; communication and negotiation between professions and between organisations; individual personality as help or hindrance in collaboration; leadership within collaborative projects; individual and group behaviour in collaborative work; resources for collaborative work; and the nature of ideas about collaboration.

2h.

Post Qualifying Studies in Child Protection

Prompted by the Cleveland Enquiry into alleged child abuse (Butler Sloss, 1988), the ENB established a working group in co- operation with CCETSW. Outline curricula resulted for two new courses in child protection, a short course (10 days) and a longer course (60 days). Funding was obtained from the Department of Health to pilot them and the contract awarded to a London- based consortium for whom Stanford and Yelloly (1994) reported.

The aim was "to determine an effective model for the development of shared teaching and learning in courses preparing nurses and personal social services professionals for their role in child protection". Evaluation employed case study and illuminative approaches. Data collection included: participant observation of the planning, organisation and teaching; completion of questionnaires by students and their managers; semi-structured interviews with students and teachers; and scrutiny of documentary sources.

The short course was competency-based, outcomes including ability to work with other professionals, to ask for help and refer cases on when appropriate, within a common framework of knowledge and understanding of law, policy, practice and procedures. It centred around a recognition of the challenge posed for interprofessional working by the complex phenomenon of child abuse. Adult learning methods were adopted which drew upon participants' existing knowledge and skills in the real world of work. The approach was therefore active, experiential and facilitatory, making full use of peer group learning. Participants met one day per week for ten weeks, organised into three modules.

Formative assessment was assisted by participants preparing personal profiles to review and up-date their own estimation of the stage which they had reached professionally and personally in relation to child abuse. Summative assessment comprised critical incident analysis reports.

The 16 participants for the first intake came from nursing, therapy, police, leisure services and youth work. Health visitors and social workers were explicitly excluded on the grounds that the content would have been covered in their qualifying courses. The absence of these two key groups set limits upon the extent and nature of the interprofessional learning.

Evaluation forms were completed by participants at the end of each module. Responses tended to focus upon satisfaction with presentation and content, Stanford and Yelloly noting a need in future to relate participants' observations to outcome criteria.

The longer course set out to enable participants to work effectively in multiprofessional networks. It aimed to provide participants with "serious intellectual fare", including knowledge of research methods and findings, the law, and a range of theoretical and conceptual frameworks. Nevertheless, the course was strongly work-related. Like the short course, emphasis was put upon learning from experience in interprofessional groups.

The pattern of study was day release, fortnightly, over two years. Assessment comprised four written assignments in the first year and one in the second. Participants (11 in the

first intake and six in the second) came from social work, health visiting and other branches of nursing. The social workers tended to be younger than the nurses, but to have stronger formal educational attainments.

Participants completed questionnaires at the outset and at the end of the second term. The first solicited information about their prior experience and training, and their expectations of the course. The second solicited information on the degree to which those expectations had been met, what respondents had most liked and least liked about the course to date, and their assessment of their progress in meeting the learning objectives. Participants were also interviewed twice and views on the value of the course canvassed from service managers.

Ten participants completed the first questionnaire, but only six (all nurses) completed the second. These latter reported positively on what they had gained, including meeting expectations regarding interagency work and improvements in their own practice, but less satisfied participants might have been amongst the non-respondents. In spite of these limitations, the authors assert that "remarkably little" difference was found in how social workers and nurses perceived the course.

2i.

Postgraduate Studies in Mental Health

Entitled "Innovations in Mental Health Work" (Shears et al. 1995), the aims of a postgraduate course at the London School of Economics were to enhance support for people with long term mental health needs in the community, to enhance the profile of working with this client group and to demonstrate that such work can be rewarding and is interesting without glossing over the difficulties. It was for experienced professionals in health and social services. They came from nursing, social work and occupational therapy, while staff came from nursing, social work, psychology and psychiatry, with service users and carers also contributing to teaching.

The course totalled 60 days (day release), half in college and half in the student's own workplace. College-based learning took place mainly in informal seminars and workshops, utilising skills and experience brought by students. Work-based learning required students to innovate, while involving users and carers in the change process. In addition to developing skills in innovation, the course also did so in care management, networking, engagement and participation with users and carers, and long-term counselling.

Evaluation had to reflect the value bases of the course, and be suitable for adult learners who were experienced practitioners. Direct observation of students' practice was deemed to be neither useful nor feasible. In the event assessment was modified to include personal learning journals and "evaluation questionnaires"

In the journals students kept track of events in and surrounding the course in relation to their thoughts and feelings. These were shown to teachers and contributed to the assessment of progress as well to the evaluation of the course.

"Evaluation questionnaires" were constructed from discussions with users, carers and

mental health workers (from various professions). Reflecting the course's commitment to competency- based outcomes, "qualities" included were:

1 to listen and act upon what users and carers say their needs are;

2 to be an effective communicator;

3 to be a good motivator of others;

4 to be flexible and open to change;

5 to know the responsibilities of self and others under the Mental Health Act 1983;

6 to know the responsibilities of self and others under the NHS and Community Care Act, 1990;

7 to know how to find and access resources;

8 to work effectively with other workers;

9 to be committed to working with service users and other workers;

10 to look for the potential in people and situations rather than only the problems;

11 to be available to users and carers on their terms;

12 to take decisions in consultation with carers and users.

These qualities were then expressed as constructs on a five point scale ranging from "always" to "never".

Students in the 1993 intake each completed three questionnaires during their first term. Similarly, questionnaires were completed by their line managers, and a user or carer with whom each student was working. The first questionnaire assessed students' practice a year ago, the second their current practice and the third how their practice might have changed in one year's time.

Response rates were 70% from students, 63% from line managers and 60% from users/carers, but two thirds of all respondents declined to complete the last questionnaire. It was decided therefore not to use it in the analysis, but a follow-up questionnaire will be administered one year after these students have completed the course.

Data were organised for analysis using repertory grid techniques. In general, change was in the direction of perceived better practice. That was significantly so in the case of students for constructs 2, 3, 6 and 9, for line managers for constructs 4, 6, 7, 8, 11 and 12, but for users and carers on only 6 and 7. The researchers inferred that benefits felt by students had been noted by colleagues, but had not filtered through to users and carers at such an early stage in the course. That, they thought, might change as users and carers engaged with students in effecting innovations.

2j.

Case Studies in Matrimonial Conciliation

A distinctive initiative (Woodhouse and Pengelly, 1991) was prompted by evidence put to the working party on "Marriage Matters" (Home Office, 1979), first, to the effect that marital stress could not be regarded as the exclusive province of specialised services and, second, that failures in collaboration between agencies and professions were frequent.

Woodhouse and Pengelly's study was about the nature of working partnerships between practitioners and client, and between practitioner and practitioner over clients whom they have in common. It focused upon interactive processes – conscious and unconscious – within these relationships and between relationship systems. They reported on their experience in working over three years with 54 practitioners engaged in marriage guidance – general practitioners, health visitors, marriage guidance counsellors, probation officers and social workers. Thirty four completed the whole programme of fortnightly meetings.

Participants were grouped into workshops with up to ten members. For the first six months each profession had its own workshop (GPs and health visitors being combined for logistical reasons). They were then regrouped into mixed workshops, representing all five groups, but working in the same locality to increase the chances of having clients (or patients) in common. These workshops met over two years, followed by six months for collective evaluation. At each meeting a group member presented a current case for discussion. These were often worrying and perplexing. In all, 132 cases were presented.

The workshops had two aims: to develop existing knowledge of how marital stress may be linked with other problems that preoccupy social and health services; and to study and seek to improve working relationships between practitioners from different agencies and disciplines since responsibilities were often shared.

The frame of reference was psychodynamic, drawing upon experience gained from marital psychotherapy at the Tavistock Institute of Marital Studies. This recognised that marriage is a transference relationship in which practitioners, like partners, become the object of projections. Where two practitioners are involved transference occurs between the marital partners, between client and worker, and between workers. "Denial" and "splitting" between partners induced similar behaviour between practitioners and between agencies (Mattinson and Sinclair, 1979). This carried added implications where practitioners came from different professions or agencies.

Other work (Hornby, 1983; see also Hornby, 1993) had shown how agency boundaries were invoked by practitioners when faced with anxiety and uncertainty about their capacity to cope with clients' needs as much as by suspicions entertained about the practice of their opposite numbers. Such anxiety reinforced "socially organised defences" against anxiety and conflict in the working environment which found expression in adherence to administrative and technical procedures, established attitudes and role relationships (Jacques, 1951 and 1955; Menzies Lyth, 1970).

Evaluation was based upon accounts written up by participants about their own cases, a log kept by each consultant and tape recordings of all meetings.

2k.

General Practitioner and Practice Nurse Trainers

Recognising the need to develop a course for practice nurse trainers, the University of Exeter extended its established course for general practitioner trainers on an experimental basis. The assumption made was that learning needs of the two groups were similar. Both were thought to require help with educational theory, curriculum design and assessment techniques, and in developing interpersonal and communication skills. Furthermore, the time seemed ripe for them to work together in small groups in an effort to overcome barriers that impeded relations as colleagues in primary health care teams.

The course lasted for a week in residence. The 36 participants comprised 24 general practitioners and 12 practice nurses. The four tutors were all from general practice, but a practice nurse facilitator acted as a resource.

Aims included: gaining familiarity with educational theory, using educational resources appropriately, enhancing awareness of self and one's impact on the learning situation, becoming familiar with the principles of teamwork and resolving problems in working with others, applying a wide range of teaching and assessment methods, and acquiring awareness of the importance of learner- centred teaching.

Each participant was assigned to one of three groups based upon the results of personality tests and questionnaires to evaluate learning styles.

After exercises on the Sunday night designed to cultivate cohesion, each group augmented and elaborated its own aims and objectives for the week. During the following three days the programme was "fairly structured", but for the remaining two days each group chose its own topics.

Each session was assessed by the participants using global rating scales. Results of pre- and post-course tests of knowledge of educational theory and of the role of nurse practitioner found large improvements by both professions. Changes in attitude were measured on a scale of one to five for 40 statements relating to interprofessional issues. Most revealing was evidence of a shift away from the general practitioners being dominant as the week progressed. By the end both were "equally interactive".

2l.

Joint Preparation of Practice Teachers

Believing that shared practice learning might well hold the key to collaborative practice, the Central Council for Education and Training in Social Work (CCETSW), the College of Occupational Therapists (COT) and the English National Board for Nursing, Health Visiting and Midwifery (ENB) launched the Joint Practice Teachers Initiative in 1989. It was founded upon three principles: first, that effective professional education is rooted in competency models of professional activity; second, that training should concentrate on the tasks and responsibilities of professions and employing authorities; and, third, that training be organised collaboratively in order to emphasise common elements in "repertoires" of the various care professions.

These principles were seen to emphasise the importance of work- based learning for students and good supervision in all three professional fields. Furthermore, the then impending implementation of policies for community care sharpened "perennial efforts to secure collaboration across professional and agency boundaries". Helping students to make the most of placements in settings which reflected the shared nature of professional work was one way to equip them with the attitudes, knowledge and skills which would help them to work closely together in the new directions which health and social care were taking.

Within that context, the Joint Initiative assumed strategic importance. The Department of Health made a grant over three years to develop joint training for practice teachers/ clinical supervisors in health and social care. A joint steering group advised CCETSW (the budget holder) in making pump priming grants to modest projects. Criteria for allocating funds were: existing joint working upon which to build; commitment to equal opportunities; anti-racist and anti-discriminatory practice; and the development of systems for monitoring and evaluating project outcomes. Guidance was offered on terminology; approaches to comparative learning; supervision; anti-racist and anti-discriminatory practice; the identification of common skills and methods in skills teaching; and comparative assessment of practice competence; similarities and differences in professional value systems; and cost benefits of learning together.

Four projects were funded during 1990/91, five during 1991/92 and three during 1992/ 93 throughout England and Wales.

A national conference in 1990 generated broad agreement about core content and competencies required by practice teachers (CCETSW, 1990). Two national workshops were then held in 1991 and 1992 to support the projects and to discuss common issues, followed by regional meetings for later projects. A key output from these meetings was the development of a common core module for community practice teachers and clinical supervisors which has been endorsed by all three parent bodies.

Stephen Brown (1993) was commissioned to make an intermediate evaluation, taking into account those for the separate projects. His task was to find out why some projects succeeded while others failed, and to avoid "re-inventing wheels".

External factors were said to be major determinants of success or failure. These included the extent and quality of collaboration both in the placement and in the college setting. Projects which had carefully identified local priorities of health and social services authorities, and had geared their developments accordingly, were able, said Brown, to secure better co-operation, which weighed in favour of their success. Much seemingly depended upon the degree to which colleges understood current service developments and were willing to define their goals in local and immediate service terms. Projects with concrete aims seem to have been more successful.

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ISBN 0 95 20 830 19