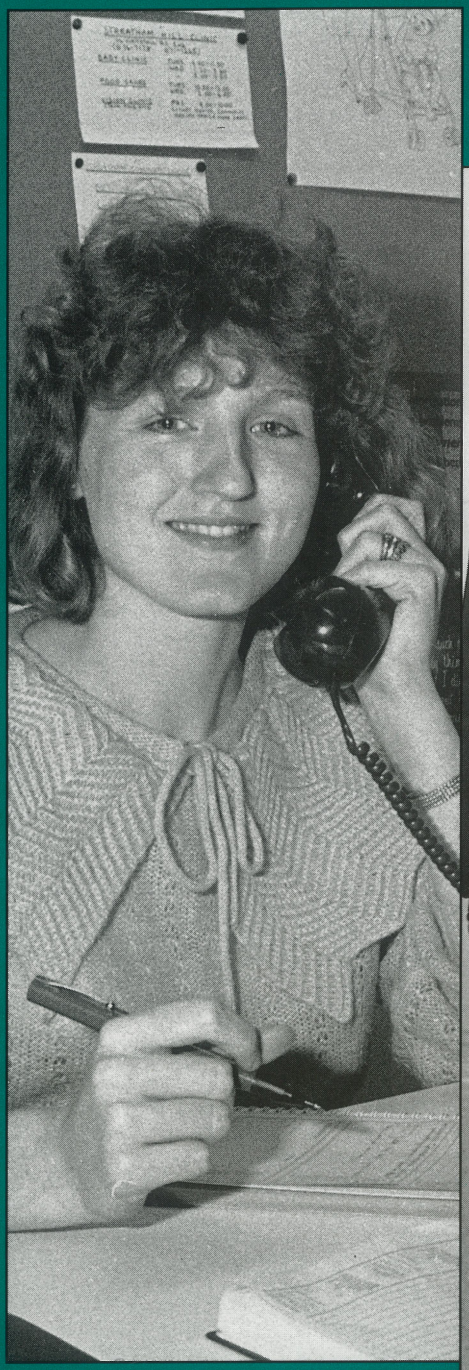
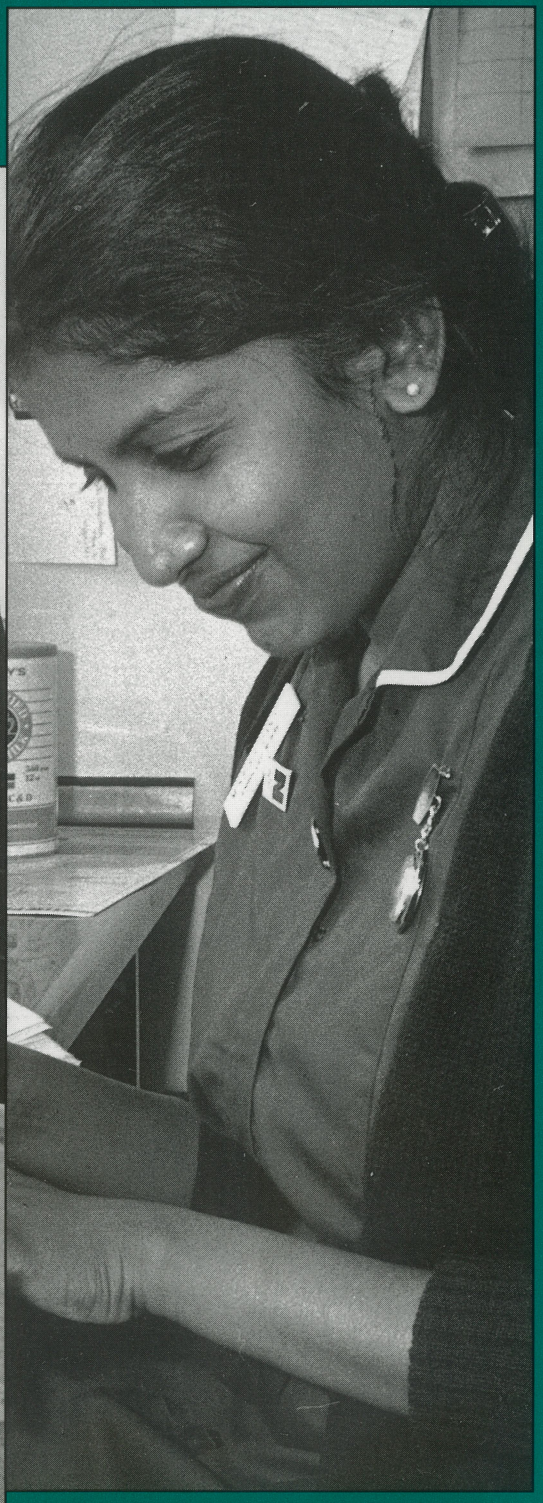
Sewing the Seams for a Seamless Service

A review of developments in interprofessional education and training

Jenny Weinstein





CCETSW

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A Review of Developments in Interprofessional Education and Training

by

Jenny Weinstein

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To all the colleagues from different professions with whom I have worked in the past three years to forge links for the development of interprofessional education and training. In particular I should like to acknowledge the support and encouragement I have received from Claudette Brown, John Horder, Peter Mathias, Georgina Smith, Dyllan Tomlinson, Helena Lowe, Ros Kingston and Judith Steele.

Preface

This occasional paper evolved from a literature search undertaken as part of an MSc research project in 1992/3. As such, it is fairly limited in its scope and any views expressed are those of the author and not of CCETSW.

Jenny Weinstein
March 1994.

Foreword

The health and welfare services are highly complex multiprofessional organisations. General management has been introduced and there is pressure for improvement in the integration of services. To make this a reality, however, professional boundaries and barriers must be re-examined, or else the health and welfare services will not ensure quality of services to the patient/client/consumer.

This publication is timely, and it is an important contribution to the literature on joint training, interprofessional education and work relationships. It brings together the existing literature on joint training within the health and welfare services of the 1990s. Further, it shares information on how health and welfare professionals can go forward to develop joint, interprofessional and interagency collaboration which is responsive to patients'/clients' needs.

Important issues relevant to training and working together have been highlighted and questions asked. These include:

- What is common to the education and training of health and welfare professionals at both basic and post-qualifying levels?
- What are the areas where professional ideologies differ, and how can such ideologies be identified and reflected on positively? Pertinent are debates around the delivery of care and personal services in a way that is sensitive to sexuality, gender, ethnicity, class and disability.
- What are the issues to be addressed in complex cases of child protection where different agencies are involved?
- How can care be managed to meet the needs of vulnerable adults, children and families if there is no alignment of teamwork skills in the planning and assessing of needs?

This paper challenges those who develop, write and put into practice the curricula for health and welfare courses to provide academic and practice settings that will guarantee that interprofessional issues are identified and analysed. Discussions about procedures and processes will continue, but health and welfare professionals must strive for the general principle that good interprofessional work is more likely if they participate in joint training.

Are interprofessional education and joint training programmes coming into their own? Only time will tell. There are many obstacles. Changes threaten and may cause resistance to co-operation, and validating bodies may be slow to rise to the challenge.

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1. Introduction

Government Guidance on the National Health Service and Community Care Act 1990 and the Children Act 1989 emphasises the importance of interprofessional work and the need for joint training. The community care legislation also radically alters systems of service provision by introducing the purchaser-provider split, with its much tighter financial controls, and replacing senior professionals with senior administrators to manage the new mixed economy of welfare.

These changes have evolved from a range of critiques of health and welfare service delivery from both the Left and the Right. Since Mrs Thatcher's election, the postwar consensus about the value of the welfare state has disintegrated and the previously marginalised ideology of the New Right (Hayek 1960), which advocates the need to curb both the costs and the inappropriate dependency incurred by the welfare state, has dominated social policy.

While public opinion has remained supportive of the NHS and welfare services, there has been considerable sympathy with criticisms from the Left of the élite self-perpetuating professions and their remoteness from the real needs of service users and their carers (Illich 1977).

Professional reactions to these developments have been mixed. The purchaser-provider split is seen by some as a cynical cost-cutting exercise (Biggs 1991), while others welcome it as the vehicle for a more user-centred approach, whereby professionals work in partnership with users, and services are more accountable.

At the same time there have been a number of developments in professional education, the most significant of which is probably the proposed introduction of National Vocational Qualifications (NVQs)[1] in Health and Social Care at levels 4 and 5, which will be equivalent to professional qualifications. The NVQs, in particular, and developments in professional education in general, have moved the emphasis away from the acquisition and testing of a specialist body of knowledge to the demonstration of professional competence in practice (Ellis 1988).

The competency approach to professional education is rejected by many professionals and educationalists who see it as a threat to the continuation of the specialist knowledge and skills required to meet users' needs (Webb 1992). Enthusiasts, on the other hand, see its potential to resolve issues of overlap between professionals. They also regard it as an opportunity to identify simpler tasks which can be undertaken by less qualified personnel (Thompson and Mathias 1992).

It is within this context of changing ideology, general attacks on professions, and new systems of service delivery, that professionals are being urged to train together.

This occasional paper is the outcome of a small literature research review undertaken in England as part of an MSc research project. It has been adapted to include some of the author's personal experience of being involved with joint training, which is presented in the text in the first person.

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[1] In Scotland the vocational qualifications are known as SVQs.

It was unfortunately not possible, within the time and resources available, to extend the project to encompass the context and experiences of joint training in Scotland, Northern Ireland and Wales. The differences in legislation and systems of service delivery in these three countries of the UK warrant attention in their own right, and will almost certainly give rise to additional issues which are not addressed in this paper.

Within these limitations, the paper aims to shed some light on a number of key questions of interest to those who are planning to organise joint training. It does so by bringing together a range of literature and research reports on the subject and setting them in the changing context of health and welfare in the 1990s.

2. The changing context for interprofessional training

This section provides an overview of welfare legislation and Government policy - both in a continual state of flux - as they impinge on the development of joint training. In some ways the present climate is one of opportunity, with flexibility to introduce new styles of organising training; in other ways it creates an atmosphere of defensiveness and resistance to change.

Welfare ideology

The major difference between the changes which took place within health and welfare during the 1960s and early 1970s and those which have been taking place since the late 1980s is that the former occurred within a context of almost universal consensus about the positive benefits of a collectivist welfare state (Mishra 1984). Today both the Keynsian economics and the Beveridge principles on which the welfare state thrived in the twenty-five years after the war have fallen into disrepute (King 1987).

Mrs Thatcher's election in 1979 heralded the beginning of the radical shift in ideology which began to bear fruit in the late 1980s. Enthusiasm for the ideas of the New Right was fuelled by the urgent need to respond to rapid demographic changes and to put brakes on the escalating costs of the health service (Leathard 1990). The solution to the problem was to be the introduction of a mixed economy of welfare which would bring the rigours of the marketplace into the provision of health and welfare services.

While the 1960s and 1970s were a time of expansion in health and welfare services, with increased career opportunities for professionals, Klein (1989, p. 216) argues that the introduction of competitive tendering has meant staff reductions and worsening pay and conditions. Walker (1989, p. 22) points out that 'contrary to the market perspective, the lowest price is not necessarily in the best interests of the user'. Many health and welfare professionals therefore view the current changes as a threat both to their own job security (Williams 1992) and to their ability to offer a good service to patients/clients.

Government policy

Government preoccupation with the need for joint planning and co-ordination between agencies in the provision of services is not new. *A Joint Framework for Social Policies* published in 1975 proposed, among other things, 'to improve co-ordination between services as they affect the individual'. Challis et al. (1988) describe how this and other initiatives of the 1960s and 1970s to improve co-ordination were overtaken in the 1980s by the move towards a market approach and the emphasis on competition.

Research into the factors relevant to the success and failure of co-ordination during the 1970s found significant barriers, in particular costs, complex administrative machinery, a lack of political will, the strength of professional demarcations, and the limited appeal of joint policies. 'Very few real incentives for genuine collaboration were identified, while

competition for scarce resources led instead to a reinforcement of territoriality' (Challis et al. 1988). The wheel appears to be coming full circle in the 1990s.

The renewed impetus for joint or shared training for professionals in the 1980s arose mainly from the Government's new policy on care in the community. A number of inquiries into the deaths of children known to the welfare services such as Jasmine Beckford (Blom-Cooper 1985) also stressed the importance of interprofessional collaboration. This was translated into Government Guidance in the revised paper *Working Together under the Children Act 1989* (Home Office 1991), which places great emphasis on joint training.

> *Inter-disciplinary and inter-agency work is an essential process in the professional task of attempting to protect children from abuse ... The experience gained by professionals in working and training together, has succeeded in bringing about a greater mutual understanding of the role of the various professions and agencies and a greater ability to combine their skills in the interests of abused children and their families.*
>
> *It is recommended that agencies should establish joint annual training programmes on child abuse issues, with access for all professional groups in direct contact with children and families. (p. 53)*

The Utting Report on children in residential care (Utting 1991) comments on the health, education and housing problems of many young people in care. Utting stresses the importance of health, education and psychology services collaborating closely with social services at the earliest stage when the child is being assessed.

Subsequent Guidance for trainers issued by the Department of Health in 1992 on *Working with Child Sexual Abuse* recommends that 'many of the courses could usefully be run as inter-disciplinary, inter-agency events' (DOH 1992, p. 28). It also stresses the importance of management support because 'training plans cannot be successfully implemented unless they are jointly owned'.

In 1986 the Audit Commission suggested the possible extension of the common core foundation of Project 2000 (see below) to all professionals working in the community. This would 'lead initially to a basic grade `community care worker' who would act as a generalist and main contact for people in the community' (Audit Commission 1986, p. 76).

While this specific proposal has not been pursued in subsequent Government Guidance documents, it has remained a spectre for many professionals, and is perceived by some as the 'hidden agenda' behind any proposals for shared or joint training.

The White Paper on community care[2], published in 1989, makes a more general statement about joint training: 'It will be important to continue to develop multidisciplinary training for staff in all caring professions' (DOH 1989a p. 67).

Additional Guidance published in 1991 entitled *Training for Community Care: A Joint Approach* (DOH SSI 1991 para 1.6.) emphasises the importance of collaboration between health and local authorities and advises that joint training should be a feature of the

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[2] The equivalent paper for Northern Ireland, *People First*, says that 'Northern Ireland already enjoys the advantage of an integrated organisational structure embracing both health and social care. It is not therefore necessary to introduce formal arrangements such as those set out in *Caring for People* for joint working and planning between health authorities and social services authorities.'

'personnel and training strategy' in community care plans. It sees shared training as essential if services are to become more user-centred and it suggests that the training needs of staff from a variety of sectors could be met more economically if they trained together.

Advice on developing a joint training strategy (section 2, para 2.3) stresses the importance of common values, knowledge and skills, and of ensuring that equal opportunities perspectives are maintained. Pilot projects are recommended as a means of stimulating development (section 2, para 2.20). Better results are said to be achieved within a small geographical area where good relationships have been built and there is support from senior management. The Guidance also advocates the need to develop joint training opportunities which offer scope for incorporation in validated programmes (section 2, para 2.25).

3. Professions and their education systems

This section examines the impact that the so-called 'attack on the professions' from both Left and Right has had on their status and systems of education. The literature on joint training identifies this as a key factor in the resistance of some professionals and educationalists to the idea of anything other than traditional profession-specific education and training.

The professions

A commonly held definition of the professions is provided by Larson (1977, p. x): 'professions are occupations with special power and prestige. Society grants these rewards because professions have special competence in esoteric bodies of knowledge linked to central needs and values of the social system, and because professions are devoted to the service of the public, above and beyond material incentives.' This links with the traditional notion of special 'traits' or attributes associated with professions as identified by writers such as Millerson (1964).

The evolution, since the 1970s, of the context in which professionals operate has led to the view that it is no longer useful to study professionals and their education in terms of identified 'attributes'. This is explained by Bines and Watson (1992, p. 1), who maintain: ' "trait" theory not only assumes the validity of an ideal type which has actually been constructed in a particular cultural and historical context, but also ignores some of the most important aspects of the inter-action between professionals and society.'

Differences between professionals

A number of writers have reflected on the differences between professionals and the reasons for these. For example Moore (1985) describes the socialisation process whereby different kinds of people are attracted to professions for which their personalities are particularly suited. The development of their professional identity, which often includes shared stereotypes of other professions, is subsequently compounded by training and culture

Etzioni (1969) distinguishes between professions such as medicine and law, and 'semi-professions', such as nursing and social work. These distinctions have become somewhat dated in that many of the differences are rapidly disappearing in the modern world of trusts, community care and the purchaser-provider split. Whittington (1983) amplifies some of the practical factors such as work setting, status in the hierarchy, and variation and frequency of client/patient contact which differentiate modern professionals.

H. Brown (CCETSW 1992, p. 70) suggests that a more relevant demarcation between professions in the 1980s and 1990s is in terms of high or low status, which reflects the power, class, race and gender differences between them. This can be understood in terms of Foucault's (1979) conception of power as a phenomenon which is constructed throughout the social sphere and expressed through political, economic and inter-personal practices.

Hey (Pietroni 1991), writing about the professionals involved in child protection work, argues that different professionals may adopt entirely different approaches to service delivery, relating to clients and relating to each other, depending on their traditions and culture.

With reference to medicine, Dingwall (1978) asserts that medical training results in doctors becoming overconfident and dogmatic. Both Bywaters (1989) and Moore (1985) suggest that the significant area of core knowledge and skills shared by nurses and social workers often leads to conflict and competition rather than co-operation. Differences may be reinforced by the perceived academic bent of social workers compared to the more practical approach of nurses.

Using Huntington's (1981) framework for analysing the differences between professions, Hey (Pietroni 1991, p.106) identifies four different professional models:

- the *practical professional* who has a common sense approach and believes that working solutions are found by trial and error;
- the *expert professional,* who is presumed to know in spite of uncertainty and who keeps a safe distance from the client or patient;
- the *managerialist model* in which the high tier plan and develop policies while the lower tier are expected to carry out the work; and
- the *reflective practitioner* (Schon 1983) who 'recognises that others have important and relevant knowledge to contribute and that allowing this to emerge is a source of learning for everyone'.

Advocating the reflective practitioner model, Hey proposes (Pietroni 1991, p. 107) that professional education and training should encourage reflection rather than a reliance on learned facts and should emphasise the importance of context and respect for other participants in the situation.

The difficulties which arise when the values, culture and beliefs of different professions come into conflict are highlighted in the Cleveland Report (1988). This describes a disastrous breakdown in communication between doctors, social workers and police, who all played a key role in the investigation of alleged sexual abuse in Cleveland.

Minty and Trowell (Pietroni 1991) recommend that professionals should learn to recognise and overcome the kinds of barriers which lead to these communication problems. Examples include 'social defences', described by E. Jacques (1955), whereby professionals defend themselves by projecting negative stereotypes onto each other; fears of loss of control where clients or patients are shared; and unresolved leadership issues in multidisciplinary teams.

Whittington (1983) identifies procedural difficulties in collaborative working as another key factor. Although a 'taken for granted division of labour will of course prevail', conflict is hard to resolve when no one organisation within the network is in a position to overrule the others. Whittington recommends that 'the study of organisations and occupations should be a core subject' in professional education.

Where trainers work with staff from different organisations, they are likely to encounter issues such as the relative status of the organisations and the people involved, the balance of power among them, and whether they are differently affected by the changes in which they are caught up. Whether or not members of a profession feel they have a future may be a significant issue when deciding about whether to take part in collaborative enterprises (Mathias 1992 p. 109).

Attacks on traditional education and training of professions

The role and status of professionals is inextricably linked to their systems of education and socialisation. In the 1960s and 1970s, professional education was based on the notion of developing a 'body of expert knowledge' (Elliott 1972 p. 11). Friedson (1973, p. 22) defines professionalisation as 'the process whereby an organised occupation ... obtains the exclusive right to perform a particular kind of work, control training for and access to it, and control the right of determining ... the way the work is performed'.

It is some of these fundamental 'rights' that are being threatened by the so-called 'attack on the professions' from both the Left and the Right. Johnson (1972) argues that professionals overcontrol their clients, while Illich (1977) suggests that the power of professionals needs to be curbed in the interests of ordinary people having more say about the services they receive. Meanwhile the New Right has attacked the restrictive practices and political power of the professions, arguing that individuals have become overdependent on the 'nanny' state and need to resume responsibility for themselves and their families (Minford 1987). Caines (1993) also argues that professionals cost too much. He says that the view that professionals can do non-professional jobs better than non-professionals 'is simply the policy which the professional bodies pursue for widening the roles and increasing the numbers of professional staff'.

These critiques have underpinned the introduction of Citizen's Charters, complaints procedures, quality assurance systems and audits, which have cut across the previous self-regulation of the professions (Ellis 1988). They also underlie the Government's policy for a new 'seamless service' for consumers in the community and their promotion of new approaches to professional education and interprofessional training.

4. Changes in professional education for health and welfare staff

This section provides a brief overview of some developments in the educational programmes of health and welfare professionals. These developments constitute another key aspect of the context for the development of interprofessional education.

Development of National Vocational Qualifications (NVQs)

One of the radical implications of the critiques of professional education is the introduction of National Vocational Qualifications (NVQs), which essentially focus on the assessment of competence rather than the acquisition of knowledge. This means the breaking down of professional knowledge and skills into observable actions or 'core competencies', whose effects on patients/clients can be directly monitored and evaluated. Not only will practices be demystified, so that others may undertake them with shorter or cheaper training, but overlaps between the professions will undoubtedly be identified, posing a threat to jealously guarded separate training (Ellis 1988).

The foundations for NVQs are occupational standards derived through a process called functional analysis. The standards are developed by a series of industry lead bodies established under the auspices of the National Council for Vocational Qualifications (NCVQ). The industry lead body for health and social care is officially called the Occupational Standards Council (OSC) although, more commonly, it is known as the Care Sector Consortium (CSC).

The role of the CSC is to develop a functional map of the health and care sector. This involves identifying the outcomes required to meet the needs of the sector and specifying the tasks of staff working in the sector. The key roles which individuals are expected to play are then broken down into *elements* which state precisely in outcome terms what people are expected to do, together with the *performance criteria* which define the key characteristics of competent performance for each element. A detailed functional analysis is under-way, at the time of writing, on the competences required for social workers and probation officers, and a functional map is being developed to encompass the full range of health and welfare provision.

NVQs at levels 2 and 3 have already been developed to provide integrated awards for staff in health and social care. Those registering for these awards are mainly care staff in residential or day care establishments or auxiliary workers in health and hospital settings. The introduction of qualifications for this group of staff has been welcomed in the main by the professions as a means of raising standards and providing access to training and promotion for people, mainly women, whose skills were hitherto unrecognised.

Linking NVQs with academic credits

A number of academics and professional bodies have expressed doubts about the appropriateness of functional analysis for developing qualifications at higher levels. The Government White Paper *Working Together - Education and Training* (DOH 1986)

anticipated (p. 18) the 'initial anxiety' of professionals about the extension of the NVQ framework beyond level 3 and guaranteed to consult the professions and their bodies 'on how higher levels of professional qualifications can best be articulated with the proposed NVQ framework'. These consultations are now under-way with professional bodies represented on the CSC.

The Employment Department and NCVQ (Education Department 1993) have emphasised the importance of identifying and incorporating the relevant knowledge and understanding required to support occupational standards. A possible model under consideration for the development of professional qualifications in health and care is one where knowledge and understanding gained in an educational setting and assessed by examinations and assignments will be a prerequisite for subsequent demonstration of full competence assessed in the workplace (Pierce 1994).

Meanwhile the Department of Health has funded the University of York (Brown et al. forthcoming) to undertake a shared training project entitled 'Bridging Competence and Credits: Linking NVQs and CATS in an interdisciplinary Framework'. This project seeks to answer a number of questions including:

- How is equivalence between NVQs and academic credits to be assessed?
- How are relationships between levels in academic/vocational/professional frameworks to be established?
- To what extent can the concept of 'core' learning outcomes/modules/curricula be used to link recognition of learning in the different frameworks?
- How can issues of level, achievement and progression be managed in awards which combine both competence and academic credit models? (Clifton 1993).

According to Clifton, the absence of a national qualifications framework makes the implementation of a national credit structure problematic. The most obvious discrepancy is the weight given in academic systems to 'time-serving'. This is largely irrelevant to competence models which are based purely on outcomes. Although it may be possible to overcome this difficulty with flexibility on both sides, there remains the problem of reconciling the use of objective measures, as in competence assessment, with the application of subjective judgements, used currently in professional and academic education (Clifton 1993).

Assessment of academic achievement is 'norm-referenced' and graded. This means that students are to some extent compared with each other. Assessment of competence, on the other hand, is 'criterion-referenced'. Students are not competing with each other, but are assessed against predetermined criteria which they either meet or do not meet. The relationship between academic credits and professional credits is still unclear. The development of a more coherent framework and the resolution of the issues identified by Clifton will be essential groundwork for the development of interprofessional education.

Nurse education

Project 2000 (UKCC 1986) describes an educational framework for nurses which will prepare them for primary care within the community as well as for clinical work in hospitals. It says that 'joint and shared training is very likely to considerably develop and to make an important contribution to effective team working in the community' (p . 18).

The report recommends that student nurses should receive a basic grounding in the range of services available to patients, and that placements should be an important aspect of this learning . It also suggests that nurse teachers should work in settings where they will have access to educational colleagues in professions other than nursing.

Social work education

The development of a new nursing qualification was paralleled by the introduction of a new Diploma in Social Work (DipSW) in 1989 to replace the previous Certificate of Qualification in Social Work (CQSW) and the Certificate in Social Service (CSS). The Diploma identifies the skills, knowledge and values required by the qualifying social worker (CCETSW 1991). The emphasis is on the outcomes on completion of the qualification rather than the inputs to the programmes.

Research undertaken by Whittington (1992) indicates that although social workers trained on CQSW courses did learn about other professions, it was from the perspective of what resources are offered and how to access them, rather than addressing issues of communication or co-working. Requirements for the DipSW (CCETSW 1991) include the expectation that social workers must be able to 'understand and where necessary take part in procedures for interprofessional collaboration' (p. 19).

Professions allied to medicine

The McMillan Report on the remedial professions (DHSS 1973) tried to address the issue of occupational therapy's overlap with both nursing and social work by recommending a closer involvement in each other's training. This did not materialise at the time and a similar recommendation has been made in a report published twenty years on, *Occupational Therapy - The Community Contribution* (SSI 1994).

The 1990s have seen the transfer of many Schools of Occupational Therapy and similar professional training programmes into institutes of higher education where the training is now at degree level. This has been counterbalanced by a move to develop a layer of less qualified, less expensive technicians, aides and assistants via the NVQ route (Smith 1993).

Similarities and differences in educational approaches between health and social work

The different traditions from which health and social work courses are derived are exemplified in a book by Butterworth and Faugier (1992). This highlights some of the more subtle but fundamental differences of approach between nursing and social work. In exploring mentorship and clinical supervision in nursing for example, Butterworth makes no reference to power relations, gender or race, issues which would be considered fundamental to the supervisory relationship in social work (Evans 1990; CCETSW 1991). This distinction is recognised by Butterworth herself when she says:

> *It is not surprising that nursing, a profession which finds itself uncomfortable with uncertainty, is attracted to models arrogant enough to claim that mentors and supervisors 'know best'. This approach is a long way from those less certain, more facilitative models employed in psychotherapy and social work. (p. 7)*

Faugier (Butterworth and Faugier 1992, p. 19), referring to social work models of supervision, explains that nursing has traditionally been intolerant and suspicious of anything which 'smacks of indulgence'. Twinn, (Butterworth and Faugier 1992), reporting on research into health visiting field work teachers, acknowledges that they are more likely to adopt a model of 'technical training' than one which encourages enquiry.

Although these different traditions exist and must be acknowledged, they are rapidly being overtaken by three key themes which bring the educational approaches of the different professions much closer together. The first is adult learning theory (Knowles 1978); the second is the concept of the reflective practitioner (Schon 1987); and the third is the identification and development of professional competences (Ellis 1988).

Educational institutions and student funding

A number of the changes within educational institutions have proved very conducive to the promotion of shared learning. In many areas, the transfer of training courses for professions allied to medicine to a single school or department in an Institute of Higher Education has facilitated the potential for collaboration. The Credit Accumulation and Transfer System (CATS) and the Accreditation of Prior Experiential Learning (APEL) have increased flexibility and paved the way for the development of modules which can be free standing or an integrated part of an approved programme of study.

With respect to funding post-registration or continuing education in the health service, *Working Paper 10* has meant that the Regional Health Authorities now hold the budget for training (DOH 1989b). This policy has led to a significant reduction in opportunities for post-registration training as health service managers have either diverted funds to service provision or concentrated training funds on developing management and finance skills. Educationalists are rapidly having to adjust to the notion that if post-registration training is going to be viable, it will require the support and involvement of operational managers.

Co-operation between the professions in the promotion of joint training

The late 1980s and the early 1990s have seen the development of a number of organisations established specifically to promote interprofessional education and training. The joint work undertaken by CCETSW and the English National Board for Nursing, Health Visiting and Midwifery (ENB) has been documented by Elliott-Cannon and Harbinson (1993). They chart the progress of a rather wary partnership which began in the 1970s with debates about the future of training for staff working with people with learning disabilities. This partnership has now flourished and produced numerous jointly validated courses at qualifying and post-qualifying levels. Similar co-operation has occurred in Wales between CCETSW and the Welsh National Board.

The Health and Care Professions Education Forum representing all the professions allied to medicine was established in 1989. This includes in its objectives:

> *to provide a facility for closer working together of health and care professionals in preparing for and implementing changes in education and training, especially in multi-professional areas.*

In 1987 Dr John Horder, an ardent campaigner for interprofessional education and ex-President of the Royal College of General Practitioners, founded the Centre for the Advancement of Interprofessional Education in Primary Health and Community Care

(CAIPE). The organisation is run by a council with members drawn from a range of health and welfare professions. Its aims are to promote development, practice and research in interprofessional education. CAIPE mounts regular workshops and conferences, produces a quarterly bulletin and publishes occasional papers reporting the outcomes of its research.

The activities and networks built by CAIPE stimulated the establishment in 1990 of a *Journal for Interprofessional Care.* According to a statement at the beginning of each issue, the Journal is dedicated to:

> *the furtherance of whole person care within the community, primary health, hospital and other institutional settings. ... As primary health and community care moves towards an inter-disciplinary approach, real gaps in education, training, organisation, research and practice are being identified.*

The networks have continued to widen. In December 1992, a Commission on Primary Care was established by the Royal College of General Practitioners to improve services for patients through better interprofessional working facilitated by learning together. The Commission is a multidisciplinary body currently in the process of establishing a number of fellowships whose role will be to promote and develop interprofessional co-operation and education.

The above organisations have made links with the European Network for the Development of Multi-Professional Education in Health Sciences. At the 1993 conference of the Network in Krakow it was interesting to note many common issues relating to interprofessional collaboration in other European countries. Scandinavia appears to be the most advanced in terms of bringing interprofessional education into the mainstream. Some programmes in Norway and Finland are moving towards developing core modules at qualifying level for all beginning professionals in health and welfare services.

5. Views for and against interprofessional education and training

This section reviews some of the arguments as to whether or not joint training is likely to enhance collaboration between professionals. While the value of an interprofessional approach to service delivery has been advocated for a number of years, there is virtually no research to demonstrate a direct correlation between interprofessional training and improved services to clients.

The general belief that there is a link was well expressed in the Younghusband Report (1959), which said:

> *In view of the fast growing complexity and scope of modern knowledge, no one profession dealing with a range of human needs can make exclusive claim in relation to the others. Each has its essential function as well as its necessary overlap with others. This overlap is required for intelligent co-operation and teamwork.*

In the absence of conclusive research findings, writers have differed about the value and purpose of joint training. Biggs (1993) discusses the extent to which users are likely to benefit from interprofessional collaboration. He suggests that a preoccupation with interprofessional boundaries and relationships might distract professionals from the needs of users, and advises that any enterprise involving interprofessional collaboration should consult with users.

Hey (Pietroni 1991), supporting the importance of interprofessional collaboration in child protection, briefly reviews research which looks at the problems professionals have in understanding each other's views and perspectives. She identifies the challenge for the educators of professionals as 'both to socialise appropriately to a particular profession because this is functional, and at the same time to develop the intellectual scepticism and rigour which provides a degree of objectivity about one's own base and an openness to others'.

A critique by Ling et al. (1990) questions some of the assumptions made about the advantages of multidisciplinary training, arguing that professional practice is influenced by such a large number of variables, including resources, departmental policies, staffing levels and individual personalities, that it is difficult to prove that increased co-operation is directly effected by shared learning.

D. Jacques (1986, p. 69) blames the lack of collaboration, and the distinctive styles and approaches in the professional training for health visiting, medicine and social work, for the difficulties professionals experience in co-operation in practice. This theme is discussed in a number of articles about multidisciplinary team work (Hunt 1983; Marshall et al. 1979; Payne 1982), all of whom see the different education traditions of team members as one of the barriers to effective team working.

This debate is pursued in the third issue of the *Journal of Interprofessional Care.* Hevey (1992) welcomes the success of the Care Sector Consortium in developing

integrated NVQ awards which have created a generic qualification structure for all workers at pre-qualifying level in health and social care. She emphasises that the 'achievement was not only in reconciling divergent traditions and values but of devising a common language'. Hevey (1991) found that most major employers, consulted as part of a research project, welcomed the development of a multidisciplinary professional whose qualification would be NVQ Level 5.

In opposition to such developments, Webb (1992) interprets the 'new competency driven initiatives in professional education as a mask for the superintendence of expert labour by the state; as the promotion of consumer, client or user responsiveness as a vehicle for endorsing the increasingly market orientated context within which employers now operate'. He charts the recent parallel developments in social work and nurse training and argues that these are aimed at increasing state control, reducing the specialist nature of the two professions and bringing them inexorably closer together in order to produce a new 'cadre' of staff to serve the market needs of care in the community.

A more positive perception of the development of shared learning between social workers and nurses is provided in two publications about developing services for people with learning difficulties (CCETSW 1992 Thompson and Mathias 1992). These publications commend what Thompson and Mathias see as the 'collective enterprise', which has been developed between nurses and social workers and which has provided a common language 'which in turn allows practitioners to draw insights from each other's practice and could set the next step in the evolution of professions' (p. 485).

6. Joint training - some general issues

This section looks briefly at the nature and extent of joint training in the early 1990s. It also identifies some general issues in terms of advice and warnings from commentators on interprofessional education. Section 7 looks at projects developed in particular areas of practice: community care, learning disabilities, child protection and practice teaching. The key issues and themes which emerge are summarised in Section 8.

The nature and extent of joint training

In the early 1990s, we have clearly moved on from the position identified by Dr. R. Jones (1986), 'that multidisciplinary training is almost universally supported and almost invariably not practised'. Nevertheless multidisciplinary training still tends to be ad hoc and has not been introduced systematically into the mainstream of professional training.

The only significant investigation into the nature and extent of interprofessional education and training was undertaken in 1987/8 by the Centre for Interprofessional Education (CAIPE). The survey, which involved a total of 466 individual agencies, showed that most of the activities were at post-qualifying level and that 81 per cent of the training events were of not more than four days' duration (Horder 1991).

Storrie (1992) attempted to review masters programmes which include an interprofessional dimension. She had to rely on personal contacts and networking in the absence of any official information. Of the 12 programmes which she identified and studied, all but two were based in traditional single-discipline academic departments. These programmes focused on developing systems of care for particular client groups rather than addressing interprofessionalism as a discipline in itself. With one exception, all the programmes had been established since 1990.

The Dos and Don'ts of organising joint training

Practical issues

When Dr. R. Jones initiated interdisciplinary training workshops in Devon in 1977, he found that meticulous planning by the organisers was required, that it was vital to have a balance of people from each profession, and that it was difficult to match the level of knowledge and expertise of participants from different professions. In terms of teaching methods, he recommended that work with small groups based on discussion of cases was the most successful. Funnell et al. identified an almost identical list of curriculum issues in a paper presented in 1992.

Jones also describes familiar practical problems, especially finding suitable venues, enabling people to be released from work to attend, and the issue of who pays their fares and expenses. He made a number of recommendations:

(1) There should be practical guidance and co-operation between the professional education bodies.

(2) Discussions should be stimulated between course organisers and trainers at a local level.

(3) Teachers in all professions should have prior experience and commitment to inter-disciplinary training.

(4) A mechanism for funding joint learning should be established.

(5) A minimum of 1 week inter-disciplinary learning should be obligatory in all studies in community care. (R. Jones 1986)

The importance of involving service managers is a constantly recurring theme in the literature (Bines and Watson 1992; Brown 1993). This is because service managers to a large extent hold the purse strings for professional education. Dufton (Bines and Watson 1992) stresses the importance of funding arrangements and the need for a constant dialogue between regional funders, professional bodies, practitioners and trainers.

Content and structure of programmes

The content and structure of joint programmes is another important area for consideration. Phil Druce (CCETSW 1992, p. 42) advises that: 'Even well-formulated training programmes will not achieve their aims unless they are also internally consistent and externally compatible with their organisational context. Training and management must be seen as different parts of the same continuum.'

Culture and attitudes

A number of commentators stress the importance of acknowledging professional differences and bringing conflict into the open. Bines (Bines and Watson 1992, p. 129) warns of the danger of superficiality as a result of which the problems of carefully monitored professional boundaries are not really overcome. The development of a truly interprofessional perspective requires an honest acknowledgement of conflict and difference in order to 'engender a reframing and synthesis of perspectives and problems'. Huntington and Shores (1983) support this position, arguing that it is healthier for professionals working together to 'agree to disagree' than not to air differences. Tomlinson (1989, p. 88) also identifies the problems caused when conflicts are not addressed. He sees this as being partly due to a reluctance to undermine the convention 'that professionals hold each other in mutual regard'.

Minty and Trowell (Pietroni 1991) advise that the 'tribalist tendencies' in all professions should be acknowledged in multidisciplinary training and should be countered by stressing that the professions are interdependent. This may be achieved by using an interprofessional teaching team as a model of good interprofessional collaboration (p. 119).

Managing change

The introduction of an interprofessional approach to training requires an understanding of how change is managed. S. Brown (1993) undertook an evaluation of four joint practice teaching projects and found a number of key success factors:

(1) the practical relevance of the project to the priorities and concerns of the local service authorities;

(2) a clear vision of where training is going and a practical grasp of how to get there - shared by partners in the training strategy;

(3) clarification about objectives and the identification of concrete outcomes of joint work.

Another issue relating to change management is whether it works better bottom up or top down. Wood (CCETSW 1992) presents two models of effecting change with respect to the introduction of interprofessional training. One is wholesale organisational change involving widespread effort which influences many people; the other begins with small, leading-edge pilot projects involving fewer people and with an effect mainly in the locality. In some cases, learning from the latter is disseminated and there is a wider impact. In many cases, however, the long-term consequences may be minimal, once the project comes to an end and the 'champion of change' moves on.

7. Experiences of interprofessional training projects

This section looks at some practical experiences of joint training enterprises in the fields of community care, learning disabilities, child protection and practice teaching. It includes sections on joint training between social workers and police and on a project to develop joint training of practice teachers, both of which are based on the author's personal experience. Although the projects cover a range of disciplines and focus on a variety of client groups, familiar themes continually recur.

Joint training in community care

A number of the general points identified in Section 6 are reiterated in reports on joint training projects in community care. One major initiative by the Department of Health funded joint training projects on seven sites, which were evaluated by the University of Canterbury (DOH/Joint Strategy Group 1991). The evaluation report emphasises the importance of joint training being an integral part of service developments and suggests that good joint training provides a model for joint working. A major objective is seen as: 'identifying common values, knowledge and skills across professions and creating a shared philosophy that includes the promotion of equal opportunities and anti-discriminatory practice' (p. 8).

Cultural problems are identified by Bowdler (Bowdler and Turner 1993) who organised inter-organisational community care training programmes in Bedfordshire. He found that participants in joint training experience clear tensions between enthusiasm and anxiety, and that it is vital to recognise agencies' different value bases. He acknowledges that it is impossible to find the 'right time' to introduce joint training and counsels against 'trying to put your own house in order first: You have to run with what you have.' Turner (Bowdler and Turner 1993) echoes this sentiment: 'Give up the holy Grail of truly joint training and settle for a range of flexible models.'

Bradbury, speaking at a joint CCETSW/WNB[3] workshop on community care (Bradbury 1993), argued for radical reforms in nurse and social work training. Her experience as a manager of community care services was that nurses and social workers make equally good care managers. She advocated the development of new training for those working with adults and with people with disabilities, with an emphasis on the purchasing and providing roles rather than on nursing and social work.

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[3]An integrated approach to care delivery has been established in Wales for some time. The most important example of this is the All Wales Strategy for people with learning disabilities. Collaboration between CCETSW in Wales and the Welsh National Board has also been a feature since the mid-1980s.

Joint training for social workers and nurses working with people with learning disabilities

The only projects which have developed joint training for health and welfare professionals as part of the mainstream of qualifying training are those which were established for nurses and social workers who planned to work with people with learning disabilities. Ironically, these key joint training initiatives, which were tolerated as a novelty for a marginalised group of relatively low status staff, are now perceived as a threat to professional identity (J. Brown forthcoming).

Initial proposals for joint training for Registered Nurses Mental Handicap (RNMHs) and social workers who worked with people with learning disabilities (GNCs/CCETSW 1982, 1983) were greeted with considerable hostility from both professions. Progress was not made until the mid-1980s when officers from the ENB and CCETSW began working closely together (Wulff-Cochrane and Steele 1991). Of three schemes which were originally planned, only two survived. These were evaluated following the validation stage by Walton (1989) and subsequently by J. Brown (forthcoming) once the first cohorts of students had graduated.

Walton (1989) comments on the 'formidable and frustrating' task of combining the two curricula, even though 75 per cent of each curriculum was common to both programmes. She stresses the importance of involvement and support from local service planners and the value of having a full-time project worker to develop and evaluate the scheme. One of the major difficulties encountered was arranging suitable placements and identifying supervisors who could meet the requirements of both validating bodies. Walton concludes on a positive note: 'The main motivating factor ... has been a genuine commitment to the principle of joint training as promising to produce, for the benefit of clients, people with the most appropriate skills to staff future services.'

J. Brown (1993) notes differences in purpose between the two joint schemes. Although they were both designed to meet service needs following the closure of mental handicap hospitals, one was education-led and one was service-led. Both schemes had problems in recruiting a sufficient number of students. There were also problems in gaining a balance of health and social work students, because social services were unwilling to second people to an expensive three-year course when regular social work training only takes two years.

Problems relating to culture, philosophy and teaching styles emerged from interviews with the students, and it was reported that at the planning stage a great deal of time was spent working through professional prejudices and misunderstandings. The students complained about the discomfort of being taught by two separate professions, each with its own philosophy and value base.

According to Brown, the students were in fact going through two separate trainings which were 'webbed but not welded' together. This was stressful for them and left them confused about their own professional identity. Given the complexity and disjointedness arising from combining existing programmes of study, Brown concludes that joint training needs to be designed from scratch with an open mind.

Despite all these problems, the managers interviewed by Brown were very keen on joint training, which they saw as preparing people for both assessment and care management. While reservations were expressed about the expense, and some felt that it was probably too 'high-powered' for basic-grade staff, most managers said they would use joint training courses. Brown found that thus far the jointly trained graduates are highly valued in their workplaces and achieve rapid promotion.

The original joint schemes were followed by new projects in the 1990s, designed to combine the new DipSW with the Mental Handicap branch of Project 2000. Of four such projects which gained planning agreement from the education bodies, only two survived to validation stage. The UKCC maintained reservations about the schemes. At present there is a moratorium on developing any new joint courses at qualifying level although this is due to be reviewed.

The two validated programmes have yet to be evaluated but Ward (1991), one of the project leaders, has reported on her initial experiences. She saw the main strengths of the programme as having its origins directly in the service needs of the locality and having maintained the full support of the senior managers in the Regional Health Authority who fund the students at every stage. She adopted a competency approach to the curriculum, identifying common competences from DipSW and Project 2000 while ensuring that the profession-specific competences were also included.

Joint training in child protection

Since the original version of *Working Together* (DHSS 1988) was published, inter-agency courses on child protection have been organised in most areas. In the main such courses are work-based, funded through the Training Support Programme (TSP), and are initiated by social services training departments. Staff who attend these courses are usually social workers, police officers and health visitors, although it is sometimes possible to involve teachers, probation officers, GPs, school nurses, paediatricians, and residential, day nursery and playgroup staff.

The practical problems in bringing some of these professionals together are enormous, particularly finding a time of day to suit the working hours of GPs and teachers. Pitching the programme at the right level is also difficult because of the varying degrees of knowledge and understanding of the various professions. The DOH guidelines for trainers (1992) aim to provide outline course programmes for different groups of staff, depending on their role and degree of involvement with child protection.

One of the major debates concerns the extent to which interprofessional education should be introduced at qualifying or pre-registration level. Scrine (1989) undertook a study of social work students to investigate the degree of multidisciplinary training received in child protection on their qualifying courses. She found that although most students had contact with other caring professionals on their placements, very few actually experienced joint working. A small number in her study gained considerable benefit from a joint seminar with trainee GPs but this was very difficult to organise. Scrine concludes that 'while the merits of inter-disciplinary training have been recognised, they are dismissed as too difficult to implement'.

While joint training in child protection at qualifying level remains sparse and patchy, there have been positive developments at post-qualifying level. The ENB and CCETSW have issued joint guidelines for post-qualifying training in child protection and there are currently three approved programmes in existence. Work in progress on a study of one of these courses (Stanford and Yellolly forthcoming) indicates the achievement of improved practice and enhanced interdisciplinary understanding and collaboration. An initial evaluation of the factors which help and hinder interdisciplinary course planning indicates the following success factors:

- a basis of trust and respect for differences of role and function;

- opportunities for all participating agencies to influence the planning process to ensure commitment of resources and participants;
- close liaison with Area Child Protection Committees (ACPCs) and access to joint funding;
- sufficient resources of time and staff for adequate planning and delivery;
- a 'bottom up' approach reflecting local agency needs within broad strategic national guidelines;
- effective leadership which allows a sharing of power.

Although there are considerable similarities in values, perspectives and skills between the nursing and social work groupings, the researchers are finding that in the face of anxiety about the nature of the work, these shared attributes are sometimes used to cover up or avoid fundamental professional differences.

Joint training between social workers and police

The area in which there has been the most systematic development of joint training in child protection is that of joint investigation for police officers and social workers. Following the Bexley experiment and the establishment of police Child Protection (CP) Teams in the late 1980s, the police have made a strong commitment to co-working and co-training with social workers.

I attended one of the special 15 days' Training the Trainers Programmes organised by the Metropolitan Police in 1989 for pairs of police and social work trainers. The aim was to cascade the training throughout the London area. I was subsequently involved in co-running with my police colleague a number of joint programmes for police and social workers in an outer London Borough.

From the police perspective there were a number of frustrations. Firstly, the police officers involved were all specialists working in the Child Protection Teams. Although there were some specialist child protection workers in social services, most social workers were 'generic'. This meant that more social workers than police officers needed to be trained and it was difficult to balance the numbers. Another frustration was about procedures. The Metropolitan Police have rules and regulations which are followed throughout London while each London Borough social services department has its own procedures.

From the social work perspective, the major problems focused on the clash of values. My own view was that this was a classic example of the practical professional - police officer - meeting the reflective practitioner - social worker (see p. 13). The police were inclined to 'work by the book' and to want straightforward answers to all questions. Social workers were much more inclined to look at each situation from the human perspective first, and to consider the rule book later. Although the conflicts were quite strong and quite painful, in my experience successful resolution in a well-handled joint training programme led to enhanced performance and a greater respect for and understanding of each other's roles and values.

The content of programmes was also problematic because each group had particular specialist knowledge and did not want to be bored with material with which they were already familiar. The police, for example, were absolutely clear about the law, their powers, and evidence. Social workers were more knowledgeable about child development and

family dynamics. Given the time constraints, some police officers (Metropolitan Police and London Child Protection Co-ordination Group 1991) suggested that those areas where one group needed 'remedial' help should be dealt with in a separate pre-training course, with a police officer teaching the social workers the law and vice versa. My own experience as a trainer was that it was much more valuable, in building relationships and mutual respect, to have the course participants teach each other their own areas of expertise.

In 1991 the Metropolitan Police and London Child Protection Co-ordination Group undertook a review of the joint courses and made some proposals. They identified five main areas of concern:

(1) equal opportunities issues

(2) selection and training of trainers

(3) content of the programmes

(4) evaluation and review

(5) follow-up training and support

The report's emphasis on equal opportunities issues bears out the vital importance of high quality interprofessional training on this subject to ensure an effective service to all sections of the community. My own experience was that the 'racist' and 'sexist' attitudes of police officers as perceived by social workers and the 'doctrinaire, politically correct' attitudes of social workers as perceived by police officers, were a major area of conflict on the courses. The report concludes that:

> *The key to this lies in the awareness of these issues and the facilitative skills of the trainers, who need to be able to challenge entrenched attitudes in a positive way which really effects change and does not just produce lip service to jargon or doctrine. What needs to be made crystal clear is how these issues may affect an investigation in very fundamental ways and that sensitivity and awareness are vital working tools.*

The report notes that while police trainers tend to be selected for their 'hands on' experience of child protection, the social work trainers are selected for their training skills. The importance of joint training for the trainers is emphasised, as is the importance of both trainers being present throughout the courses.

Jointly planning and jointly owning the content of the courses is seen as essential:

> *Social Services have felt that the original content of the joint courses was largely imposed on them ...*
>
> *Some of the Police are feeling that currently Social Services have ...'hijacked' the courses and imposed their own curriculum ...*

The report recommends that a core curriculum be developed by police and social workers which can be delivered across London but is flexible enough to be adapted to local needs.

It expresses concern that currently trainees on the programmes are not assessed and that attendance at the course can be seen as an automatic licence to practise in this difficult area.

Although suggestions about assessment have raised considerable anxiety among both participants and trainers, the report is adamant that the nettle should be grasped.

It may be that this could be more positively framed in terms of course participants being assessed and gaining recognition for their knowledge and skills in the form of credit towards a higher award or qualification. While this is now possible for social workers within CCETSW's post-qualifying framework, it may not be feasible for police officers for whom, currently, working in the Child Protection Teams is not seen as a positive career move.

The importance of regularly reviewing the content and methods of the programme in relation to its value to those who subsequently undertake child protection work is stressed by the Metropolitan Police and London Child Protection Co-ordination Group, as is the need for follow up training and support. Although these courses are very thorough and intensive, they are at present 'one-off' for most workers. In addition, the report notes that although joint training is available for practitioners, there is no equivalent for their first line managers and this needs to be urgently addressed. ACPCs are advised not to organise a one-off training event and believe the task is completed. Staff turnover in all the professions necessitates running a rolling programme.

Joint training of practice teachers

Practice teachers and clinical supervisors play a key role as the trainers and socialisers of the next generation of professionals within the work context. Joint training of practice teachers is controversial because practice learning/clinical practice is such a fundamental aspect of professional education that it would inevitably have a significant impact on the general development of professional education.

In a research project to explore the shared learning opportunities which might be developed for students on the Diploma in Nursing and the DipSW in Bristol, Harding (1991) focuses on the practice placement, arguing that it is the linchpin of joint training.

Harding found that although both courses espoused a similar philosophy on paper, subtle differences were apparent in the way in which the students from the different professions actually related to clients. Additionally the students were seen as 'protective of their own training' and not enthusiastic about sharing. Social workers were keen to empower clients to meet their own needs while nurses wanted to meet the clients' needs themselves. The differences would appear to be based on ideology rather than knowledge and skills.

Harding's conclusion not to recommend shared practice learning for nurse and social work students seems to be based on the views of the students and the complexities of organising the placements to meet the requirements of the respective education bodies. Issues of service need are not discussed. Harding does, however, recommend the development of joint training for practice teachers.

Another rationale for the joint training of practice teachers is one of economy and efficiency. As service managers become less willing to finance the training of practice teachers, courses are shrinking and a joint approach might make more sense. It was on this basis that Maggs and Purr (1989) undertook an evaluation of the education and training of practice teachers on behalf of the ENB. They found that course leaders were concerned about the future of their courses. The restructuring of higher education and the increased emphasis on cost-effectiveness were thought to be likely to lead to a generic practice teaching course open to all health professionals and to social workers.

An important development in collaboration between education bodies was achieved by the Joint Practice Teaching Initiative (JPTI). This involved the development and joint validation of a core module for practice teaching programmes by CCETSW, the ENB and the College of Occupational Therapy (COT) (S. Brown 1993; Weinstein 1993).

The project was steered by a multidisciplinary committee and received funding from the Department of Health to develop pilot joint training projects across the UK. In spite of considerable enthusiasm for participating in the JPTI, demonstrated by well-attended conferences and strong interest in developing pilot projects, it proved difficult to achieve fully functioning joint programmes.

An action research study which I undertook to investigate the barriers to establishing joint practice teaching programmes (Weinstein 1993) found a number of problems, many of which have been identified in other joint training project reports.

- There were insufficient links with service managers in the planning and promotion of JPTI.
- Expressed enthusiasm for joint training was tempered by a hidden agenda of fears about dilution of professional identity.
- Leaders of pilot projects had insufficient time for effective planning and collaboration.
- Individual projects felt isolated and lacked direction.
- Running a core module as part of a programme which led to two or more profession-specific qualifications was too complex in terms of practicalities such as timetable and assessment schedules.

In response to the identification of these barriers, the JPTI steering group resolved to provide systematic support to projects by employing a development worker. In addition to ensuring networking between projects, the development worker would forge improved links with managers and service providers, promote and market the project and encourage the professional bodies to develop a more user-friendly model for joint validation.

8. Summary and conclusions

This section aims to provide a brief summary of the context and experience of interprofessional education and training and of the recommendations which have been made about organising successful joint training programmes.

The changing context

The health and welfare context for interprofessional education and the relevant education systems are all in a state of flux. Health and welfare professionals are ideologically under attack from both Left and Right. They are also personally under considerable pressure owing to worries about career prospects, enormously increased workloads, and concerns about cuts and reduced services to clients. Educationalists in nursing, social work and other allied professions are all grappling with the introduction of new systems of training and there are concerns that NVQs might seriously erode the future of professional education. Many of the changes have brought the professions and their education systems more closely together, while others, by threatening the survival of individual professions, serve to increase defensiveness and rivalry.

The nature of joint training projects

Since the pioneering work of Dr. R. Jones, joint training ventures have been in the main ad hoc and fragmented. Developments have depended on initiatives from below, and even when these have been successful, they have not been incorporated into the mainstream. Small projects frequently flounder because of practical difficulties or unspoken ideological differences or because they rely on a local 'champion'. Writers differ about the advantages and disadvantages of joint training and the Government's motives for advocating it so strongly are widely mistrusted. Although there are no conclusive research findings, most enthusiasts argue that closer interprofessional collaboration is in the best interests of service users.

Advice about running joint training programmes

Successful schemes require careful attention to planning, preparation and balance of participants. It is important to take into account the different levels of knowledge and skills of potential participants. There must be firm links with local service managers and service plans. Issues of equal opportunities, culture, values and language must be addressed and conflict should be acknowledged and dealt with openly. Participative training methods and a problem-solving approach work better than didactic input. Training should be carefully evaluated and incorporated into mainstream rolling programmes rather than taking the form of one-off ad hoc activities. Where possible participants should be enabled to gain credit towards recognised academic or professional awards.

Some professional bodies still seem to be reluctant to encourage jointly validated programmes, and attempts to combine curricula to meet the requirements of validating bodies have proved complex and frustrating. The small number of joint training projects

which have been written up and evaluated, mostly in unpublished reports, indicates considerable hurdles to be overcome, particularly if validation is required. Pioneers recommend a more flexible approach which begins with the needs of the service rather than the requirements of the education bodies, and above all which has the support and commitment of service planners.

Glossary of acronyms

ACPC	Area Child Protection Committee.
APEL	Accreditation of Prior Experiential Learning.
CAIPE	Centre for the Advancement of Interprofessional Education in Primary Health and Community Care.
CATS	Credit Accumulation and Transfer System.
CCETSW	Central Council for Education and Training in Social Work.
COT	College of Occupational Therapists.
CP Team	Child Protection Team (police).
CSC	Care Sector Consortium (more commonly used name for the OSC, see below).
CSS	Certificate in Social Service.
DHSS	Department of Health and Social Security.
DipSW	Diploma in Social Work.
DOH	Department of Health.
ENB	English National Board for Nursing, Health Visiting and Midwifery.
HCPEF	Health and Care Professions Education Forum.
JPTI	Joint Practice Teaching Initiative.
NCVQ	National Council for Vocational Qualifications.
NVQ	National Vocational Qualification.
OSC	Occupational Standards Council (industry lead body for the development of standards for NVQs in the health and care sector).
RNMH	Registered Nurse Mental Handicap.
SSI	Social Services Inspectorate.
TSP	Training Support Programme.
UKCC	United Kingdom Central Council for Nursing, Health Visiting and Midwifery.
WNB	Welsh National Board for Nursing, Health Visiting and Midwifery.

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SEWING THE SEAMS FOR A SEAMLESS SERVICE

Government demands on health and care staff to provide a 'seamless' service for users have put the subject of interprofessional education and training high on the agenda. This short paper surveys recent developments within the context of the new mixed economy of welfare. The pros and cons of joint training are discussed and linked with current debates about the relative merits of professional and vocational education. Key themes and pointers for the future are drawn from a review of joint training initiatives in a range of disciplines including community care and child care.

This paper is the first in a series of occasional papers on interprofessional education and training planned by CCETSW, some of which will be produced in conjunction with the English National Board for Nursing, Health Visiting and Midwifery (ENB).

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