Chapter 1

From a collaborative and integrated welfare policy to frontline practices

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Introduction

During recent decades, Western welfare states have gone through a number of substantial transformations. One such transformation was the turn to active welfare states, based on the neoliberalist ideas of limiting the role of the state in welfare provision and emphasising citizens' responsibilities instead of rights. Along with this, there has been a transition to a managerialist mode of governance, calling for more effective and efficient welfare services, and an increasing demand to understand service-using citizens as active participants in service provision. Common to these kinds of transformations is that they travel across countries and are often defined as indispensable steps to maintain welfare states and to secure effective, fair and flexible responses to citizens' wishes and needs. In other words, these are globally promoted and shared policies of welfare states, which are then realised in national legislation and guidelines.

New managerialist modes of governing have, among a range of other features, facilitated an increasingly specialised organisation of work in social care and health services. The idea is that

specialised units of professionals will be able to develop more effective and productive service delivery due to both a specialisation of professional skills and an optimisation of procedures guiding work. However, this specialisation has produced fragmented services, which lack coherence and coordination in individual cases and between services more broadly. This has led to a call for collaborative and integrated welfare services across service sectors and national contexts. The resulting collaborative and integrated welfare policy and its accomplishments and implications in frontline social welfare service practices are at the core of this book. This policy stems from the aforementioned welfare state transformations, but it also has specific roots and justifications. It is promoted as a solution to overcome the challenges of ineffective, dispersed and professional-led social care and health services. Collaboration in this book refers to both collaboration between different professionals and organisations, and collaboration between professionals and citizens as service users. Integration, for its part, refers to the view that health and social care services should be seen as a whole, responding comprehensively to people's complex problems and service needs, in contrast to segmented sections concentrating solely on strictly targeted issues (Cameron et al, 2014; Fenwick, 2016, p 112).

Collaborative and integrated welfare is approached in this book from two aspects that are presented in the existing literature as essential for the renewal of welfare services, namely interprofessional collaboration and service user participation. They are both seen as premises for achieving collaborative and integrated welfare, and also as markers of the successful implementation of such policy. These two aspects are examined in the book as they are achieved in frontline everyday practices and encounters between professionals and service users through which the realisation of collaboration and integration is sought. Thus, the focus is not on policy and collaboration at the organisational level, but on communicative and interactional processes, which are often mentioned as critical for the successful implementation of collaborative and integrated welfare services

(Bokhour, 2006; Cameron et al, 2014; Goodwin, 2015). Furthermore, the book focuses on a specific organisational form of work, multi-agency meetings. Concurrently with the policy level call for collaborative and integrated welfare services, an increase in the number of multi-agency meetings has been observed (Blom, 2004; Julkunen and Willumsen, 2017). These meetings are regarded as boundary spaces that bring together professionals from different professions and welfare agencies, service users and (sometimes) their next of kin or lay representatives.

The following section first specifies what lies behind a transnational idea of a collaborative and integrated welfare policy. Then, the literature on interprofessional collaboration and service user participation is reviewed. This section does not just promote but also challenges these two aspects of collaborative and integrated welfare.

A globally promoted idea to solve complex problems

The idea of collaborative and integrated welfare has been promoted by the World Health Organization (Cameron et al, 2014; Fenwick, 2016, p 114), and has been adopted as one of the core emphases in government programmes for future welfare services in many Western countries (Kitto et al, 2011, p 208). As Cameron et al (2014, p 225) stated from the UK context, 'A consistent theme of policy over the past 40 years has been a concern that welfare services could be improved if agencies worked together more efficiently. In the field of adult health and social services, a variety of strategies have been introduced to encourage this agenda.' Similar movements are seen in the Scandinavian countries, such as in Finland where the government's large health and social service reforms seek more efficient and effective practices, and more integrated and well-functioning health and social care packages for individual citizens and families. Furthermore, the reforms aim to make countries responsible for giving people the opportunity to participate in developing health and social services.

From policy to frontline practices

The policy interest in and turn to collaborative and integrated welfare have been justified with a wide range of arguments. First, certain social problems and health problems are seen as interconnected (complex problems), demanding that they be dealt with together, not separately. Second, it is believed that by combining the professional expertise of various frontline workers with the experiential expertise of citizens and service users, it is possible to reach a more profound understanding of complex problems and to solve them more effectively and efficiently (Goodwin, 2015). Third, it is argued that collaborative and integrated welfare creates relational and joined-up talking and thinking that produces new and shared knowledge, instead of a mixed selection of professionals' and service users' views. Fourth, collaborative and integrated welfare is claimed to be a user-centred practice, since it treats citizens and service users as collaborators and participants, and approaches their problems and needs holistically, thereby constructing integrated care pathways (Huby and Rees, 2005; Vanhaech et al, 2010). Fifth, the advantages of shared responsibility in providing and receiving welfare services is emphasised; solving complex problems should be everyone's duty (for example, the idea of a 'Big Society').

Despite justifying arguments, collaborative and integrated work faces several challenges. Leathard (2003) cites issues at five different levels: structural, such as fragmentation and gaps between different services; procedural, such as different budgetary and planning cycles; financial, such as different funding mechanisms and flows of financial resources; organisational, such as division and organisation of work and professional groups; and professional, such as issues of status and legitimacy, and different values and views. Following the literature on frontline organisations important decisions are made at each of these levels that are not just procedural or organisational, but which translate and transform policy aims in ways that impact the frontline 'doing' of collaborative and integrated work in practice. Thus, collaborative and integrated work may take place at system and organisational levels as well as at the service user level in an effort to organise professionals'

work and clients' service packages into seamless entities (Van der Klauw et al, 2014; Valentijn et al, 2015). This means that policy is not implemented through the formulation of policy aims or a re-organisation of work alone, but must be adopted and acted out by professionals and service users in their encounters. In the words of Henneman et al (1995, p 108), 'Although organisations can be instrumental in supporting collaboration, they cannot ensure its success. Collaboration is, in fact, a process which occurs between individuals, not institutions, and only the persons involved ultimately determine whether or not collaboration occurs'.

Interprofessional collaboration

Co-operation between different professionals representing different organisations, services or professions has been defined with various concepts, such as multidisciplinary, cross-disciplinary, interagency, inter-organisational and interprofessional work or practice. Although these concepts have different nuances (Kvarnström, 2011, pp 22–24), the authors of this book use the concept 'interprofessional' with an affix of 'collaboration' (interprofessional collaboration), which is commonly used in health and social care literature. Fenwick (2016, p 113) defines interprofessional practice as 'integrated forms of practice involving workers in two or more different organisations or services', whereas Hammick et al (2009, p 205 cited in Morrison and Glenny, 2012, p 369) see it as occurring 'when multiple workers from different backgrounds provide comprehensive services by working together synergistically'. Collaboration, in turn, is described, for example, by Chesters et al (2011, p 4) as 'a key attribute of working together rather than working alongside, with the setting of shared goals (including, where possible, those of patients and their relatives)'.

Interprofessional collaboration is thus characterised by such attributes as working together across professional and organisational boundaries, integration, comprehensiveness, shared goals and

synergy. It is argued that this kind of orientation is especially needed when encountering complex, wicked (Rittel and Webber, 1973) and multidimensional problems that cannot be solved by applying the narrow or specialised knowledge of a single profession, service or agency (Goodwin, 2015). Interprofessional collaboration is argued to increase the holistic wellbeing of service users with complex service needs, rather than just concentrating on certain domains or problems in their lives.

From a critical perspective, interprofessional collaboration is perceived as an inherently good and skilled practice, with limited reflection on both its advantages and disadvantages (Chesters at al, 2011; Morrison and Glenny, 2012; Fenwick, 2016). Fenwick (2016, p 113) writes that '"collaboration" tends to be over-simplified in practice as a romanticised ideal of communication, and in policy as a universal governing imperative for professional work in public service'. Chesters et al (2011, p 1) describe interprofessional health care as an uncritically accepted 'common sense' that is close to being a dominant discourse. Accordingly, Morrison and Glenny (2012, p 368) claim that 'for the protagonists, being inter-professional is, above all, the essence of being or becoming professional, previous forms seen as increasingly irrelevant or reprehensible'. Hence, education that strengthens interprofessional skills has been promoted and developed intensively in recent decades (for example, see the *Journal of Research in Interprofessional Education and Practice*).

Collaboration is an appealing term (Morrison and Glenny, 2012, p 367). It is hard to resist the idea that collaboration, rather than individual and singular specialised efforts, produces innovative solutions to complex problems in health and social care and increases service users' positive service experiences and wellbeing. Total resistance to collaboration would not even be reasonable, since interprofessional collaboration has been shown to be an effective, responsive and user-centred practice in many service occasions and for many different service user groups. However, the evidence is not always sufficiently robust and solid (Cameron et al, 2014; Goodwin, 2015). The appealing connotations of the term should not obscure the fact that the evidence of the functionality of

interprofessional collaboration is mixed; it can produce both negative and positive practices and impacts (McNeil et al, 2013). It is therefore dangerous to regard interprofessional collaboration as a superior practice that works in all 'complex cases' without taking into account the specific requirements of the working environments, resources and personal needs and wishes of service users.

Gaining knowledge of collaboration in practice – whether it is a suitable approach in a given context or not and what outcomes it produces – demands looking closely at naturally occurring frontline service practices, where interprofessional collaboration is applied and displayed in service user-professional encounters processing individual cases.

Relational agency, boundaries and common knowledge

Interprofessional collaboration has been studied and developed as a field of research based on various theories and philosophies of knowledge, agency and interaction. For the purposes of this book, Anne Edwards' work on collaboration is interesting, since she emphasises the everyday relational processes of interprofessional practices (Edwards, 2005, 2010, 2017, Edwards et al, 2009). Her work draws on cultural-historical activity theory, whose origins can be found in the writings of Vygotsky (1978) and Leontyev (1981), and which has been elaborated further from the point of view of learning in working life and developmental work research by Yrjö Engeström and his colleagues (Engeström, 1987, 1999, 2001).

Edwards (2011, p 33) uses the term 'relational turn' to describe necessary and ongoing changes in expertise demanding interprofessional and interagency activities in working life. The foundation of the turn is in the idea of relational agency. By relational agency, she is referring to:

> a capacity for working with others to strengthen purposeful responses to complex problems. It arises in a two stage process within a constant dynamic which consists of:

(i) working with others to expand the 'object of activity' or task being worked on by recognising the motives and the resources that others bring to bear as they, too interpret it; and

(ii) aligning one's own responses to the newly enhanced interpretations with the responses being made by the other professionals while acting on the expanded object. (Edwards, 2011, p 34)

Relational agency is thus based on constant responsive interactions with other professionals, with the aim of producing solutions to complex problems (objects of activity) that are more than just a combination of individual professionals' expertise and interpretations of problems. Interactions occur at intersecting practices that create boundary spaces where it is possible to build beneficial new common knowledge and relational expertise (Edwards, 2011, pp 33–35).

Building common knowledge and relational expertise is not an easy, straightforward process. Conflict between areas of specialised expertise is an inevitable part of the process, since the familiar boundaries of professions and organisations are broken down (Frost et al, 2005). Relying on Engeström's (1999) theory, Frost et al describe the processes, discussing conflict in the following way:

> At this point, implicit knowledge must often be made explicit. Professionals have to find a common language to make knowledge accessible to their colleagues from other disciplines. . . . To understand these processes, we drew on Engeström's (1999) activity theory model in the field of knowledge creation and exchange. An important premise in Engeström's model is that conflict is inevitable as tasks are redefined, and distributed within changing organizations and teams. His premise is that such conflicts must be debated openly, as communities/teams come together with different knowledge, expertise and histories to pursue a common goal, if progress is to be made towards creating new forms of knowledge and practice. (Frost et al, 2005, p 189)

Ideas about relational agency, interaction and common knowledge are linked to constructionist and discursive theories of knowledge (Berger and Luckmann, 1966; Potter, 1996; Edwards, 1997; Burr, 2015). According to these theories, knowledge is not something that is simply possessed by individuals, based for example on their education or experiences, and occasionally delivered to other

people. Instead knowledge is seen as continually produced, negotiated and challenged in textually mediated conversations, such as scientific literature concerning knowledge about interprofessional collaboration, or in face-to-face encounters, such as interprofessional team meetings grappling with complex problems. There are difference between the theory of relational agency based on the activity theory model and constructionist theories. The former sees intersecting boundaries as a promising space for joined-up thinking and talking, producing innovative and useful new knowledge, although usually only after conflicts have been debated. By contrast, the latter is more open to the possibility that interactions in boundary spaces can also result in competitive struggles between different types of knowledge and the repression of certain stakeholders or 'voices'. In the end, it is a matter of empirical research to find out how knowledge is created, contested and shared in the boundary spaces of frontline services, and with what consequences. As Edwards (2011, p 34) notes, 'we know all too little about how common knowledge is built at the boundaries of systems or practices'. Hence one aim of this book in to demonstrate both how common knowledge is constructed in boundary spaces such as multi-agency meetings, and how different domains of knowledge may come into conflict with one another or be given hierarchical value.

Blurring boundaries, power relations and the risks of shared responsibility

Edwards' conceptualisation of collaboration as relational processes that are continually produced and negotiated in responsive interactions calls attention to the actual doing of collaboration in frontline practices in health and social services. The potentials of interprofessional collaboration are contingent on the practical accomplishment of such work; however, interprofessional collaboration may also produce negative results. The often taken-for-granted potentials of interprofessional collaboration are challenged by literature that identifies risks in this approach. Here three lines of concern are addressed.

The first line of concern is that interprofessional collaboration threatens professional identities, creates intolerant attitudes towards differences in professional knowledge and requires professionals to 'assimilate' into a generic care culture with generic roles (McNeil et al, 2013). Certainly the opposite view exists, that interprofessional collaboration depends on strong professional identities and domains of expertise, with the sharing of a wide range of professional knowledge without it being merged into a single entity. Nevertheless, professionalism is often mentioned as one of the main obstacles or even threats to the strengthening of integrated care, since 'professionalism would seem to progress individualistic rather than cooperative tendencies as professionals seek to protect specific tasks and craft knowledge which may determine the type of team practice' (Coyle et al, 2011, p 45). Professionalism can easily result in boundary work, where different professions and service agencies draw rigid demarcation lines by claiming that their skills and jurisdictions cover one particular domain of work but not another (Gieryn, 1983; Abbott, 1995; Allen, 2000; Hall et al, 2010, 349).

Frost et al argue that:

> joined-up thinking has profound implications for the concept of professionalism and how we think about professional knowledge and practice. It can be argued that traditional claims to professional expertise are based on developing expertise in specific professional fields, the antithesis of joined-up thinking (Frost, 2001). In multi-agency teamwork, professional knowledge boundaries can become blurred and professional identity can be challenged as roles and responsibilities change. (Frost et al, 2005, p 188)

On the one hand, more permeable boundaries between professions can be seen as a precondition for interprofessional collaboration and innovative joined-up thinking. On the other hand, there is a danger that distinctive professional knowledge and approaches to solving complex problems are lost in the process of blurring boundaries and reaching for a shared understanding. Sometimes 'orientations of different professions to the same problem can be diametrically opposed' (Fenwick, 2016, p 115). Accordingly, Morrison and Glenny write that

> services enjoined to 'collaborate' may be on different projects and, indeed, varied epistemological and action-oriented 'pathways', sometimes towards divergent 'destinations'. For example, educators intervene to include children and young people in education, social workers to protect those children most vulnerable, and health services to heal; in each case, these endeavours are driven with internal contradiction. (Morrison and Glenny, 2012, p 371)

All these endeavours by educators, social workers and health professionals are valuable in their own right and require specialist knowledge and expertise. Therefore, bypassing these domains of specialised expertise and the tasks of different welfare organisations to concentrate primarily on common knowledge creation and shared aims can, at worst, produce negative impacts for people with complex problems by missing the opportunity to reach genuinely interprofessional, multifaceted conclusions.

The second line of concern brings up power relations between different professionals. The sociology of the professions has a long history of discussing such issues as interprofessional competition, monopolies of practices and hierarchies between professions (Reeves, 2011). In the pursuit of interprofessional collaboration it is essential to understand and challenge culturally embedded power relations (Fenwick, 2016, p 116). The professions do not enter arenas for interprofessional collaboration as equal partners free from stereotypical categorisations and expectations. For instance, the dominance of the medical model in health and social care settings and the authoritative roles of health professionals, especially doctors, have frequently been discussed and demonstrated in the literature (Abramson and Mizrahi, 2003; Long et al, 2006, p 509, p 516; Nugus et al, 2010). However, medical dominance does not necessarily mean that the expertise of other domains is not respected; rather, it is regarded as complementary to the primary medical expertise.

The third line of concern discusses the responsibilities of different professional parties in interprofessional collaboration. Joined-up thinking and talking includes the idea of members of interprofessional teams having shared responsibility for solving complex problems in individual cases

(Hewitt et al, 2014). According to Morrison and Glenny (2012, p 380) this diffuses responsibility, and there is a risk that a 'reduction in personal responsibility is not complemented by a comparable assumption of responsibility by service coordinating teams'. Sharing and blurring responsibility might obscure who has the final decision-making power, and who ultimately takes responsibility for what in complex cases (Fenwick, 2016, p 113; Dall, 2018). This sometimes leads to situations where, from the point of view of service users, no one seems to have decisive responsibility.

The concerns that have been raised in relation to the idea of interprofessional collaboration should be taken seriously and studied carefully in a variety of settings. Doubts and contradictions about interprofessional collaboration may materialise in some health and social care settings but not necessarily all, nor in every individual case, nor at all times in the same way. Empirical research that concentrates on everyday interprofessional collaboration is the means for finding out how interprofessional collaboration in shifting contexts is realised in practice, and whether the abovementioned concerns are justified. Such research lies at the heart of this book.

Service user participation

In recent decades, the topic of service user participation has been widely discussed and studied in health and social care across Western societies (e.g. Beresford, 2002; Kvarnström, 2011; Kvarnström et al, 2012; Kvarnström et al, 2013; Matthies and Uggerhoej, 2014; Raitakari et al, 2015; Juhila et al, 2017, pp 337). In the literature, participation is related to concepts such as self-determination, human rights, full citizenship, user involvement, consumer choice and empowerment. The basic argument is that citizens should occupy a position of authority, and along with that, have the opportunity to influence and make decisions on matters of importance to them.

The expectation that service users should have a more active and powerful role regarding their own wellbeing and their health and social care services has emanated from a variety of sources (Pilgrim and Waldron, 1998; Drake et al, 2010). National policy documents and legislation globally have articulated the importance of service user involvement. Similarly, service users, as well as health and social care professionals in various settings, have promoted the principle of participation (Cahill, 1996; Collins et al, 2007; Browne and Hemsley, 2008; Kvarnström, 2011, p 8; Kvarnström et al, 2012). Service user participation is also a core principle in the ethics codes of health and social care professions, and the service user movement has played a significant role in highlighting user participation as a human rights issue (see for example Bassman, 1997; Cook and Jonikas, 2002). Professionals, for their part, are seen as responsible for encouraging, enabling and supporting users to use this right.

The ideal of service user participation challenges interprofessional collaboration that occurs solely between different professionals and agencies. As Kvarnström (2011, p 24) writes, the use of the term interprofessional collaboration seems to exclude service users and people close to them. Thus, her suggestion is that it is better to replace that concept simply with collaborative practices, where service users are understood as partners with their own expertise. Nowadays, it is a widely-held view that collaborative practices should not be exclusively interprofessional, but should include service users and their significant others, such as their parents and carers (Morrison and Glenny, 2012, p 369).

Service user participation is commonly understood both in terms of individual and collective participation. At the individual level, it is considered important that service users are provided with information and that they are active in setting goals, defining support measures and making choices regarding their personal services. At the collective level, it is emphasised that service users, as an important stakeholder group, should be involved in the planning, providing, assessing and researching of services (Beresford, 2002; Lammers and Happell, 2003; Kvarnström, 2011; Raitakari et al, 2015).

In this book, the focus is on individual participation in that it examines how service users participate and are treated as participants in their own personal matters in integrated, collaborative and multi-agency health and social care meeting practices. We thus use the term participation in the broad sense of service users being present and participating in discussions regarding their individual case and situation. Whether or not this amounts to having an active influence on decision making and care planning is an empirical question to be examined in the individual encounters.

Service users as participants in creating knowledge in collaborative practices

Applying Edwards' ideas about interprofessional work and relational expertise to collaborative practices, including both professionals and service users, means that service users are understood as important participants with relational agency, producing solutions to complex problems. This corresponds with the general shift described above – from services provided *by* professionals *for* clients, to the increasingly common view that practices (should) unfold *with* service users as active participants (Hopwood and Edwards 2017, p 108). Service users' expertise and interpretations of problems concerning themselves are regarded as important resources in creating common knowledge and relational expertise in boundary spaces. What is also in focus here is the communicative construction of common knowledge in mutually responsive ways. This relational foundation of professional-service user collaboration places specific demands on professionals, who have to balance the use of their specialist expertise against the risk of compromising the idea of collaboration and partnership with clients. Hopwood and Edwards (2017, p 109) suggest that the establishment of common knowledge can be an important mediating factor in achieving such a balance, but they also emphasise that the concept of common knowledge 'does not imply that . . . "what matters" must be(come) the same. Indeed the different insights associated with different motives are seen as strengths in partnership approaches'. Professionals (and service users) should thus attempt to facilitate

encounters in which it becomes possible to work with differences and explore what they mean for the unfolding collaboration.

Such a conceptualisation highlights service user participation as 'a complex, emergent phenomenon located in practices and specific settings, rather than something that can be reduced to procedural prescription' (Hopwood and Edwards 2017, p 117). It also means that the question of whether participation is best understood as service users' relaying information, offering interpretations, collaborating in defining and solving problems or autonomously making decisions in their own cases becomes an empirical question to be examined in naturally occurring encounters between service users and professionals.

Power relations, responsibilities and the risks of social engineering and stigmatisation

Following the conceptualisation of service user participation as contingent on communicative and negotiated practices, it is perhaps no surprise that the ideals of participation are met with certain concerns regarding its realisation and fulfilment in health and social care. Here three concerns are addressed.

The first concern is similar to the second concern regarding interprofessional collaboration, namely power relations in interactions. Just as different professions do not enter collaborations as equally valued and trusted participants, free from pre-existing stereotypes, nor do service users. Service users might be treated more like objects than subjects in interactions, whose situations and troubles are 'diagnosed' and conceptualised by various professionals using their special expertise and knowledge. Furthermore, service users can be categorised in advance into certain 'client types', such as a carrier of a substance abuse addiction or a long-term unemployed person with pre-determined attributes, which does not give them much space to present their identities in different and personal ways. It can also be the case that instead of equal and shared collaborations between all parties, particular alliances

or sub-groups emerge. For example, professionals may ally with each other 'against' the service user's interpretations of his/her own situation, or one professional may ally with the service user to advocate her/his right to their own voice in interactions. Boundary spaces then become 'battle fields' for different viewpoints and blocs.

The second concern relates to the balance between service users' right to be involved versus their responsibility to participate. Kvarnström (2011, p 18) writes, 'the concept of service user participation is associated with the dimension of active social citizenship as well as rights to be active in contacts with health and social care services'. The rights perspective includes, for instance, such privileges as being entitled to get information and support from professionals in increasing one's self-determination, to have a strong voice in interpreting one's own situation and needs, to make choices concerning services, and to have permission to challenge professionals' judgements and discretionary power. In addition to the rights perspective, the service user's active citizenship and participation are increasingly understood as the service user's responsibility. However, it can be argued that individuals should also have the right *not* to become involved or participate (Juhila, et al, 2017, p 37). Since service users have different interests and capacities to participate, the option to be non-active must be available (Hickey and Kipping, 1998; Lammers and Happell, 2003, p 387; Fischer and Neale, 2008; Raitakari et al, 2015). When emphasising the service user's responsibility to participate, it is not understood as an individual's choice and right, but as a duty of citizenship and as a governmental technology to overcome exclusion and welfare dependency (Jayasuriya, 2002; Paddison et al, 2008).

The third concern raises the question of whether collaboration is always in the best interests of the service user. Is it what the service users want and wish for? For service users, collaborative and integrated practice means that instead of different professionals working with them separately in different organisations, several professionals from various organisations deal with their situations and problems simultaneously towards shared aims. The principle of integrated care is based on the holistic

idea that health problems and social problems are somehow connected and should be met and tackled together with all relevant parties. This can mean, for instance, endeavours to create one, shared assessment process (see Dickinson, 2006) and one care plan in collaborative practices for each service user. Certainly collaborative and integrated practice can have many advantages for service users. It may reduce visits to different services and the so-called 'revolving door' phenomenon. It can create comprehensive interpretations of service users' life situations that service users find useful in their life planning. However, from a critical point of view, collaborative and integrated practice can be seen as a form of social engineering, purporting to reach into all domains of life (Morrison and Glenny 2012, p 371). Service users might sometimes prefer not to participate in interprofessional collaboration, if given the option to make that choice. For example, service users may regard their mental health problems and unemployment issues as unrelated issues that should not be dealt with simultaneously with every professional involved. Service users may prefer discussions with one trusted professional at a time, if they feel uncomfortable discussing their lives in multi-agency meetings with several people present. They may also feel that being a service user in integrated services is stigmatising, since they are defined as persons with complex problems and needs. According to Morrison and Glenny (2012, p 371), 'service users may have to present themselves as dysfunctional, helpless, or disabled in some way before integrated service is made available to them'. In terms of the possible negative sides of collaborative and integrated practice, a relevant question is whether the principle of service user participation allows the user the choice of refusing or challenging such participation.

Collaboration and integration in action: teamwork and multi-agency meetings

Collaborative and integrated practice that includes both different professionals and service users cannot exist without interactional arenas where it can be accomplished. Multi-agency meetings constitute one such arena and one that has been increasingly utilised, as welfare policies have emphasised the need for collaborative and integrated services (Blom, 2004; Julkunen and Willumsen, 2017). Literature in health and social care often covers such meetings in terms of 'teamwork', and the ability to conduct teamwork is seen as a fundamental element of health and social care systems (Coyle et al, 2011, p 39; Morrison and Glenny, 2012, p 376).

Multi-agency meetings in health and social care may take the shape of case conferences, case planning meetings, network meetings, team meetings and so on. Each type of meeting has specific aims for assessing, planning for or resolving service users' complex cases, and may also be structured around specific interactional norms and procedures. Multi-agency meetings are a common way to structure and implement collaborative and integrated welfare; however, we still know very little about communication and interaction in such meetings (Bokhour, 2006).

The established way to understand teamwork in health and social care is as communication and work done together by professionals representing different professions and agencies. In a literature review, Xyrichis and Lowton (2008) find that enhanced communication achieved through team meetings is a means to ensure effective teamwork, and conversely, that a lack of communication is the source of misconceptions, conflicts and breakdowns of teamwork. When teamwork is successful, it may fulfil the following primary aims: '(1) to provide the best patient care possible, (2) to make joint interdisciplinary decisions, (3) to coordinate care amongst professionals, and (4) to complete the written treatment plan' (Bokhour, 2006, p 353). However, in practice, service users are not necessarily seen as having an active role in achieving these goals in teams and their multi-agency meetings.

At one extreme, service users may not even be present at meetings, leaving the discussion of their situations and problems to the professionals. However, the growing policy-level emphasis on the importance of service user participation means that nowadays service users are often invited as participants to multi-agency meetings regarding their personal matters, and their presence can even be considered indispensable for successful meetings. Nonetheless, even where service users are present in meetings, their position may still vary a great deal. For example, some studies have shown that service users are treated mainly as informants about their current situation, troubles and wishes, with professionals retaining the power to process this information and make plans and decisions concerning the service user's future (Hitzler and Messmer, 2010; Juhila et al, 2015). Furthermore, multi-agency meetings can place high demands on vulnerable service users in terms of the communicative abilities needed to make their voice heard, even when professionals are attuned to the service user as an active participant.

Despite these challenges in the very structure of meetings, multi-agency meetings that include service users can, ideally, function as arenas in which 'the ''best'' possible knowledge about the client's situation is present and where the participants share and negotiate the responsibilities for working toward common goals' (Berger and Eskelinen, 2016, p 100). Indeed, if the idea of collaborative and integrated practice is taken seriously, service users must be viewed as full team members, whose knowledge is understood and valued equally with that of other participants (Chesters at al, 2011, p 3). This resonates with Edwards' concept of relational agency and the building of common knowledge in responsive interactions. However, it is important to ask whether and what kind of roles, rights and responsibilities service users and individual professionals have in relational agency and in the creation of knowledge.

While the policy movements towards more collaborative and integrated welfare are present and almost universally supported across health and social care settings, as well as across national welfare

states, the realisation of such ideals in practice is less clear-cut. In particular, this is related to the various challenges of implementing policy in practice. As the literature on street-level bureaucracy and organisations (Lipsky, 1980; Brodkin, 2011) has effectively demonstrated, frontline organisations can be understood as *de facto* policymakers in the sense that they informally (re)construct policy in the course of everyday organisational life (Brodkin, 2011, p i253), although they do not determine the explicit policy content. How collaborative and integrated welfare policy is brought about in practice is thus highly contingent on the organisation and management of work as well as the conduct of professionals and clients in everyday encounters. This book focuses on analysing encounters in multi-agency meetings, which although crucial for accomplishing collaborative and integrated welfare, they can also reveal the dilemmas, complexities and failures in implementing this policy-level ideal. This raises several questions for further examination, some of which include:

- How are relational agency, (new) boundary spaces and common knowledge constructed (or not constructed) in the meetings?
- Can blurred professional boundaries be dysfunctional, for instance, by obscuring responsibilities between the parties, and if so, how can this be identified in meeting interactions?
- What patterns of participation appear in the meetings among professionals and service users?
- Do service users have a choice regarding whether and how to participate in the meetings (responsibility versus right to participate)?
- Who collaborates with whom in meetings – professionals with each other, some professionals with service users or all participants together?
- What kinds of positions are given to and taken by service users in multi-agency meetings (outsiders, informants, decision makers and so on)?

- How are hierarchies of different knowledge and expertise, including service users' knowledge and expertise, produced and negotiated (or not) in the meetings?
- How is service user knowledge based on personal experiences valued (in relation to professional knowledge) in the meetings?
- Are there signs of stigmatisation or downgrading of service users in the course of meeting conversations?

This list encapsulates our preliminary interests in examining multi-agency meetings as arenas where it is expected that collaborative and integrated welfare will be realised. The next chapter provides more precise methodological premises and analytic tools for doing such analyses.

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