

**Accomplishing social work identity in interprofessional  
mental health teams following the implementation of the  
Mental Health Act 2007**

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## List of abbreviations

AC: Approved Clinician

AMHP: Approved Mental Health Professional

ASW: Approved Social Worker [former name for what is now the AMHP]

CA: Conversation Analysis

CMHT: Community Mental Health team

CPA: Care Programme Approach

CPN: Community Psychiatric Nurse

CTO: Community Treatment Order

EM: Ethnomethodology

GSCC: General Social Care Council

HCPC: Health and Care Professions Council

HoNOS: Health of the Nation Outcome Scales

HoNOS PbR: Health of the Nation Outcome Scales Payment by Results

OT: Occupational Therapist

Physio: Physiotherapist

PICU: Psychiatric Intensive Care Unit

## Abstract

The main objective of the thesis was to explore how social work Approved Mental Health Professionals accomplished social work identity when seconded to Mental Health Trusts. The project has examined the identity work that the social workers engaged in as they located themselves within interprofessional interagency community mental health teams. Insights from ethnomethodology and conversation analysis have been used to examine the interview data. Following Wieder (1974), the findings chapters are presented in two parts. In the first part, the focus is on the interviews *as a resource* and thus there is a more traditional reporting of *what* the social workers talked about in the interviews. Throughout the interviews, the social workers were concerned to delineate what was 'real' social work. Real social work was depicted as involving autonomous work in the community with mental health service users; this is the 'authentic realm of social work' (Pithouse 1998 p.21). Social work identity was portrayed as intrinsic to the self with congruence between personal and professional identity and values. However, the social workers struggled to define social work. Instead of having a clearly defined role, social work was depicted as intangible; as being without clear margins and boundaries, filling in the gaps left by other professions. Notions of 'dirty work' (Hughes 1948) and the implications of being seconded to a Health Trust are also discussed. The analytic focus shifts in the second part to the interview *as a topic*, specifically to *how* social work identity was accomplished within the interview as interaction. Matters such as being a member, the part played by the use of humour in the interviews, and the interaction *as a research interview* are explored. Finally, there is an examination of how social work identity was accomplished through the telling of atrocity stories.

## Introduction

Social work as a profession is viewed negatively in the media and, arguably, by the general public. Recent cases, such as that of Daniel Pelka, Hamzah Khan, and Khyra Ishaq have compounded an already negative image of social work. The foreword to the Final Report of the Social Work Task Force (2009) acknowledged that social work has arrived at a watershed moment. My research aimed to examine how social workers accomplish and sustain a positive social work identity within this social and cultural context.

Mental health social workers have experienced a great deal of change in their working practices since the implementation of the NHS and Community Care Act (1990) and the introduction of the Care Programme Approach in 1990. Initially based in Social Services Departments within a Local Authority with other social workers, mental health social workers have been separated from other social workers and are now based in Health Trusts with health professionals. There may be only one or two social workers in any one team. My research has examined the identity work that social workers engaged in as they located themselves within interprofessional interagency community mental health teams. I was particularly interested in how social workers accomplish and sustain a social work identity in a context where professional boundaries are shifting and there is confusion caused by role blurring.

The Mental Health Act 2007, implemented in November 2008, made a fundamental change to the role of mental health social workers by extending the unique functions of the Approved Social Worker to health professionals within the Community Mental Health team. This means that nurses, psychologists and occupational therapists can also take on the role of what is now called the Approved Mental Health Professional. In addition, the introduction of Community Treatment Orders under the Act appears to be in conflict with the social work value base of user empowerment, self-determination and social justice. Furthermore, the new roles of Approved Clinician and Responsible Clinician mean that social workers can

now take on functions previously performed by the Responsible Medical Officer who had always been a Psychiatrist. My research aimed to explore how the recent implementation of this legislation had impacted on social work identity.

The Government have produced a plethora of policy documents relating to the mental health workforce since 2003 including the Mental Health National Occupational Standards (2003); The Ten Essential Shared Capabilities for Mental Health Practice (2004); New Ways of Working Interim Report (2004); The Guiding Statement on Recovery (2005); New Ways of Working Final Report (2005); Options for Excellence: Building the Social Care Workforce of the Future (2006); Our Health, Our Care, Our Say (2006); Reviewing the Care Programme Approach (2006); Mental Health: New Ways of Working for Everyone (2007); Mental Health Act 2007: New Roles (2008) and No Health Without Mental Health (2011). These documents are concerned with workforce challenges in mental health and discussed the extension of traditionally defined roles and the creation of new roles. For example, the New Ways of Working Final Report (2005) accepted that the identity of social workers is a key issue and acknowledged that one of the future challenges in terms of social work identity concerned the replacement of the Approved Social Worker by the Approved Mental Health Professional. The report concluded (2005 p.118) that there is a clear need to maintain and nurture social work identity to help with recruitment of social workers. Thus, issues of social work identity are clearly identified as a policy issue that needs to be explored further. Additionally, the recent implementation of the Mental Health Act 2007 means that this is a new area of research.

In terms of impact, the research is directly applicable to everyday social work practice. This aligns with the view of many social work researchers that social work research should both inform and be informed by social work practice. For example, Butler (2002 p.241) argued that social work research is to 'be considered as occupying the same discursive site as the practice of social work and the same operational domains. Its subjects, fields of interest and audiences must coincide'.

It was my intention that the mental health social workers who participated in my research would find it a useful and helpful experience which would then have a positive and affirmative effect on their social work identity. In turn, hopefully this would have also benefitted the service users that they work with.

However, social work identity can be conceived of in many different ways. For example, in a recent article, Fran Wiles (2013) outlined three approaches to social work professional identity. For the participants in Wiles' study (2013), professional identity can be thought of in relation to desired traits, drawing on a 'professionalism' discourse based on the sociological argument that all professional groups share certain traits. Secondly, professional identity can also be used in a collective sense to convey the 'identity of the profession', drawing on a collective sense of being a social worker. Finally, taking a more subjective approach, Wiles (2013) found that professional identity can be identified as a process in which a social work student comes to have a sense of themselves as a social worker, drawing on personal experience, as a resource for constructing professional identity.

In contrast, rather than conceiving identity in terms of inner traits or in terms of structural factors such as professionalisation, Carolyn Taylor and Sue White (2000) have argued for a social constructionist position. Taylor and White (2000 p.100) have rejected the assumption that professional identity is something which is acquired outside and prior to the encounter with the service user through the medium of training and regulation. For Taylor and White (2000 p.100) identity is constituted in talk and identity and becomes a topic to be investigated rather than a resource to explain someone's behaviour. This is the approach that is taken in this thesis. In their book, *Practising Reflexivity in Health and Welfare*, Taylor and White (2000) have drawn on a number of different sociological frameworks including Foucault and Discourse, ethnomethodology, conversation analysis and discourse analysis. The approach taken to social work identity in this thesis comes from one of these approaches – ethnomethodology.

## Objectives of the research

The objectives of the project were to:

- Explore how the social work identity of social workers based in Mental Health Trusts is accomplished using an ethnomethodological approach.
- Investigate the impact the implementation of the Mental Health Act 2007 has had on the social work identity of social workers in mental health teams.
- Examine the nature of the contribution that social workers make to interprofessional mental health teams.
- Contribute to the development of the ethnomethodological approach within the context of mental health social work research.

# 1 A Natural History Approach to the Methodology Chapter

## 1.1 A Natural History Approach

David Silverman (2010) suggested that instead of mirroring the conventions of quantitative research reports, a natural history approach to the methodology chapter may be more appropriate for qualitative research. He argued that:

... readers will be more interested in a methodological discussion in which you explain the actual course of your decision making rather than a series of blunt assertions in the passive voice... your examiners will be interested to know something about the history of your research, including your response to the various difficulties and dead ends that we all experience. (Silverman 2010 p.334-335)

This chapter will take this approach and explicate the history of my research in order to make explicit the process of decision-making about the directions that I have taken throughout the research process.

## 1.2 Being a mental health social worker

Day one of my research project began with an interview with a Professor of Social Work for an Economic and Social Research Council 1+3 Studentship in Social Work. Due to administrative confusions, I had only been notified of this interview the day before and so had one evening to develop a research proposal. I thought about the question that had puzzled me most since becoming a qualified social worker: when I met other social workers, why was it that I thought 'she's such a social worker' or, conversely, 'she's so not a social worker'? I imagined telling the Professor that this was what I wanted to research and how he would laugh at such a bizarre and non-academic proposal.



Again turning to my experience as a social worker in mental health teams, the research proposal that I eventually presented was to examine how mental health social workers sustain a social work identity when seconded to Health Trusts - with a particular focus on the introduction of the Approved Mental Health Professional role under the Mental Health Act 2007. Luckily the Professor thought that this was a good proposal and asked me to outline the methods for data collection. At that point in time, I only knew two methods: surveys and interviews. I knew that I wanted to 'talk' to people so I opted for the latter. The Professor asked "*semi-structured?*" and I nodded.

I am telling this story to depict my initial status as a complete novice to research. The research proposal was borne of a mixture of naivety and my own personal experience as a mental health social worker.

### **1.3 Interviews: "*semi-structured?*"**

The use of the interview is ubiquitous to the extent that we are an 'interview society' (Atkinson and Silverman 1997) and being a social worker means being an expert in interviewing. Social workers interview people as an integral part of their work; it is one of the core tasks of social work practice. As such, social workers are 'veterans of the interview' (Pithouse 1998 p.187). My initial and somewhat naïve assumption that the responses given by interviewees would allow me to gain access to their experiences of being a social worker was soon challenged. For the +1 part of my ESRC Studentship, I completed the doctoral programme offered by the Sociology Department which was essentially the taught modules of the MRes in Sociology. Here I discovered many approaches to data collection and analysis, and realised that conducting interviews was not the straightforward matter I had originally presumed. Fontana and Frey (2005), for example, list many different approaches to interviewing, including creative, postmodern, empathetic, and gendered interviewing. The words of Ann Oakley (1981 p.41) accurately represent the confusion I felt at the time: 'Interviewing is rather like a marriage: Everybody knows

what it is, an awful lot of people do it, and yet behind each closed front door there is a world of secrets’.

Silverman (2006) outlined three versions of interviews: positivism; emotionalism; and constructionism. Reading through these, I realised my proposed approach fell under emotionalism; wanting to access ‘emotions’ and ‘experiences’ as if they were self-evidently present in the interview data (Silverman 2010). Silverman (2010 p.127) noted that this leads to ‘analytic laziness in considering the status of interview data’. Suitably chastened, I read on. Within the section on constructionism, Silverman discussed the work of Jaber Gubrium and James Holstein and noted that:

... this approach is a useful antidote to the assumption that people have a single identity waiting to be discovered by the interviewer. By contrast, it reveals that we are active narrators who weave skilful, appropriately located, stories. (Silverman 2010 p.132)

Wanting to learn about this ‘active interview’ approach in more depth, I wrote about it in an assignment for the MRes. Jaber Gubrium and James Holstein first outlined their active interview approach in a book, *The Active Interview*, which was published in 1995. Since then, they continued to develop the approach in a series of books and articles (Gubrium and Holstein 1997; 1998; 2000; 2003; 2006; 2007). The active interview is not a particular type of interview, to be distinguished from other forms of interviewing. Instead it can be seen as offering a competing epistemological model of the interview with its own set of methodological and analytic principles. In contrast to the traditional interviewing models which see the interviewee as a passive vessel-of-answers, Gubrium and Holstein (1995) argue that that all interviews are interpretively active, involving meaning making practices on the part of both interviewers and respondents. For example, a woman caring for her mother with dementia uses phrases such as ‘as a daughter’, ‘as a wife and mother’, and ‘sometimes I put myself in my husband’s shoes’. Gubrium and Holstein (1995 p.16) argued that she displays considerable narrative activity as these ‘resources are astutely and adroitly crafted to the demands of the occasion, so that meaning is neither predetermined nor absolutely unique’. The lack of guidance and examples

on how to actually analyse interview data led me to continue to explore other approaches to interviewing. However, certain elements of this approach stayed with me; in particular, the understanding that interviews are interpretively active, involving meaning making practices on the part of both the interviewer and the interviewee.

#### **1.4 The literature review**

The next part of my 'search' for a methodological approach involved doing a literature review. I decided to concentrate on empirical research so that I would gain an overview of published research in the field. For these reasons, I chose to do this in the form of a systematic review. This review is set out in the next chapter. Although the approaches used in two of the twenty articles that were included in the review interested me (Peck and Norman 1999; Gregor 2010), none of them seemed to 'fit'. I continued my search.

#### **1.5 Narrative interviewing and social work**

After continuing to explore different approaches, I finally chose to use the narrative approach to interviewing. My rationale for this was that this approach seemed to resonate with social work: the construction and performance of identities is central to narrative research and central to social work. Social workers deal with narrative all the time: narratives are found in multi-disciplinary meetings, ward rounds, initial assessments, case records, and reports. The persuasive function of narrative is relevant for social work as social workers construct cases from the narrative work of service users. In their review of the use of narrative in social work research, Catherine Kohler Riessman and Lee Quinney (2005 p.395) concluded that relationships are a hallmark of both social work and the narrative approach. Social workers engage with service users, listen to their accounts and try to understand how they see the world. Thus, both social work and narrative interviews require the ability to 'follow people down their trails' (Riessman 2008 p.24). Like social work,

narrative interviewing depends on the interviewer's emotional attentiveness and engagement. The narrative approach is also appropriate for researching social workers as an identity group. Identity groups use stories to foster a sense of belonging (Riessman, 2008 p.8).

A key issue for my research is that I share the same professional identity as my participants. Riessman (1990) discussed this issue in her research about divorce. Here, being a divorced single parent helped to establish rapport with her interviewees. However, Riessman recognised that this can have both negative and positive effects:

I wanted their, not my, understandings, and in some ways I had to work harder and probe more than I would have if I had not been seen as veteran of the experience. At the same time, the fact I was divorced placed me in a more egalitarian relationship with those I was studying and created a greater reciprocity than is customary in research interviews. Being a survivor of the experience also helped me attend to subtle but very important cues. (Riessman 1990 p.226)

Reading this was a key moment as I realised that I would need to be explicit in the analysis about the impact that shared understandings and assumptions had on the research process.

## **1.6 Narrative research: An overview**

Narrative research is a particular type of qualitative research. Narratives 'recount efforts to grapple with the world in all of its confusion and complexity' (The Personal Narratives Group 1989 p.263). However, there are many different approaches within narrative research. In her review of narrative research, Chase (2005 p.651) found that:

Contemporary narrative inquiry can be characterized as an amalgam of interdisciplinary analytic lenses, diverse disciplinary approaches, and both traditional and innovative methods – all revolving around an

interest in biographical particulars as narrated by the one who lives them. (Chase 2005 p.651)

Riessman (2008) outlined the three main approaches to textual narrative research and analysis. These were:

- The thematic approach.
- The structural approach.
- The dialogical approach.

What follows is a brief overview of these approaches to narrative research and analysis as presented by Riessman (2008).

### **1.6.1 The thematic approach**

Researchers using the thematic approach focus solely on the content of the words spoken by the interviewee. Analysis examines 'what' is spoken and there is little or no emphasis on any contextual factors. Consequently, this means that 'in the written report, it appears that a biographical account emerges 'full blown' from the 'self' of the narrator' (Riessman 2008 p.58). This approach seemed to be a form of the emotionalist research discussed by Silverman above.

### **1.6.2 The structural approach**

The structural approach is concerned with the content of the words but there is also a considerable emphasis on the form the narrative takes. The structure is seen as significant and the researcher is concerned with how an account is made coherent and comprehensible. Analysis examines how the narrator uses form and language to achieve particular effects. The structural approach was developed by William Labov and Joshua Waletzky in their 1967 article on narrative analysis. Labov and Waletzky (1967) argued that a 'fully formed' narrative contains six elements:

- An abstract (a summary and/or the 'point' of the story).

- Orientation (to time, place, characters, situation).
- Complicating action (the event sequence, or plot, usually with a crisis or turning point).
- Evaluation (where the narrator steps back from the action to comment on meaning and communicates emotions – the ‘soul’ of the narrative).
- Resolution (the outcome of the plot).
- A coda (ending the story and bringing the action back to the present).

The work of Labov and Waletzky (1967) ‘remains a touchstone for narrative inquiry’ (Riessman 2008 p.81). However, the structural approach pays little attention to context and the role that the interviewer plays in co-constructing the narrative is not examined. However, I have found this approach useful; particularly in recognising the importance of the coda to the narrative.

### **1.6.3 The dialogical approach**

Unlike the structural and the thematic approaches to narrative, the dialogical approach is concerned with how talk is interactively (dialogically) produced and performed as narrative. From this approach, the researcher is recognised as an active presence and accounts are seen as co-produced:

Investigators carry their identities with them like tortoise shells into the research setting, reflexively interrogating their influences on the production and interpretation of narrative data. (Riessman 2008 p.139)

In terms of analysis, those researchers using this approach preserve accounts rather than fragmenting them. The part played by the interviewer in the dialogue is kept in the lengthy excerpts included in the research text. To conclude, the dialogical approach to narrative research accords with the epistemological and ontological approach to interviewing that I have taken. Specifically, I used the dialogical approach of Elliot Mishler and Catherine Kohler Riessman.

## **1.7 Narrative and identity: Elliot Mishler and Catherine Kohler Riessman**

After reading studies by many of the contemporary narrative researchers, I found that the work of Catherine Kohler Riessman powerfully resonated with me.

Riessman is a former social worker and this may explain why I felt a connection with her overall approach and analysis of the narratives of the people that she has interviewed. Riessman has been influenced by the work of her former teacher and mentor, Elliot Mishler. In her book, *Divorce Talk* (1990), Riessman described how Mishler supported her through a 'paradigm shift' that she experienced during her interviews with divorcees. Initially Riessman used a quantitative survey approach to the interviews but the project was completely transformed when she began to see this approach as inappropriate and inadequate. Riessman (1990) described how:

I began to see divorce as an interpretive process, not as a series of stages. I became intrigued with the imaginative enterprise itself – how individuals, through talk, construct meaning out of loss, and how gender is meaningful in this interpretive work. The subjects had changed the investigator and, thus, the research. (Riessman 1990 p.227)

Riessman acknowledged her deep debt to Mishler (Riessman 1990 p.xiii). This prompted me to read Mishler's work and, again, I found this highly relevant. Thus, my research approach to interviewing was based upon the work of Riessman and Mishler. I will now describe some of their work in more detail and show how it relates to my own research.

### **1.7.1 The contribution of Elliot Mishler**

Mishler's book, *Storylines* (1999), is particularly relevant for my research as it is concerned with narratives of professional identity. The primary aim of Mishler's interviews with craftartists corresponds with the aims of my research. Mishler (1999 p.21) wanted 'to learn about how they came to their work, what it meant to them, and how it functioned in their lives... how their work identities were achieved and

sustained. In addition, my research questions are very similar to those of Mishler in this study. Mishler (1999) was interested in:

The types of claims made and how they are warranted; how the craftartists specify their identity claims and how these function in their lives; and how their identities are performed and situated in the ongoing discourse of the interview. (Mishler 1999 p.20-21)

For Mishler, people do not have a fixed, static identity that can be excavated through the interview process. Thus, the focus moves from identity as a one dimensional fixed set of personality traits situated within any individual to identity as a dynamic relational concept. Mishler (1999 p.112) was concerned with how the craftartists made 'identity claims on the basis of their social position, aligning or contrasting themselves with others; how they mark out boundaries and limits of their relationships'. Mishler viewed narratives as identity performances, how people speak their identities. For Mishler, we 'continually re-story our pasts' (Mishler 1999 p.5) and thus there is an inextricable link between time, memory and narrative. Mishler (1999 p.136) suggested that there is a 'dialectic of opposition where one's claim for a positive identity may be justified by contrasting it with another's negative identity'. Therefore, identity claims involve defining those who are 'other'.

### **1.7.2 The contribution of Catherine Kohler Riessman**

Riessman is one of the key writers on the narrative approach to interviewing. Her study of infertility with women in South India was concerned with identity construction. In particular, Riessman (2002) examined how the women resisted stigma when infertility occurred. She provided a detailed analytical account of how one of her interviewees, Gita, constructed a positive identity through her narrative performance. Riessman (2002) explained that Gita's performance:

...suggests how she wants to be known, her preferred self – a "perfectively" normal woman "with no defect at all." The way she organizes scenes within the narrative performance, the choices she makes about positioning, and the grammatical resources she employs



put forth the preferred identity of committed political activist, not disappointed would-be mother. (Riessman 2002 p.704)

Riessman's study is relevant to my research as both are concerned with identity construction. She showed how Gita constructed a positive identity in order to avoid stigma. In her recent comparative ethnography, Leigh (2013a p.224) found that social workers in England are 'collectively stigmatised by society'. The Final Report of the Social Work Task Force (2009 p.48) concluded that the public image of the profession seemed to be 'unremittingly negative'.

## **1.8 The process of ethical approval**

Sharing the same occupational identity gave me a heightened sense of the potential impact of participating in the research interviews for social workers within a Community Mental Health team (CMHT). Initially I planned to interview all the social workers in one or two mental health teams. However, this would have meant that, at the very least, the other members of the team may have been able to identify the comments made by any individual social worker. This had great potential to be harmful to the social workers involved and could irretrievably damage their relationships with the other members of the mental health team. As Laurel Richardson (1997 p.117) stated: 'I wouldn't want to "give voice" to real live people who know each other and could identify each other in my text. For me, it might be "text"; for them, it is life'. To minimise this risk, I decided to interview individual social workers recruited via advertisements in social work publications. Obviously, this decision had an impact on the research. Instead of the social workers being in a team and thus part of a social network, the social workers would all be unconnected individuals.

Gaining ethical approval from The University of Salford's Research Ethics Panel proved unproblematic. The panel accepted my proposal without requiring any clarification or further information.

## **1.9 Access**

The day after I received ethical approval, I met another doctoral student in social work at a conference. I told her that I now had to try and recruit social workers for my study but I was unsure how to go about this. The doctoral student suggested that making contact with the National Lead for AMHPs in England and Wales to ask for some advice. The National Lead immediately replied to my email and said that she would be happy to pass on the information sheet outlining my research to all the AMHP Leads who could then pass it on to the AMHPs in their area. Within a week I had about fifty emails from AMHPs agreeing to be interviewed. Thus, the chance meeting at the conference and the welcoming response by the Lead AMHP meant that access was easy. As Law (1994 p.37 quoted in White 1997 p.78) stated: 'It's [about] what you have, what you know *and* whom you know'.

## **1.10 Recruiting social workers**

The emphasis in narrative research is on detailed extended accounts from a smaller number of participants. For example, Mishler (1999) interviewed five participants for his study on craftartists. In her 2004 research paper, *A Thrice told Tale*, Riessman provides an in-depth analysis of her interview with one participant, Bert. In addition, the interviews were likely to be lengthy (approximately 90 minutes each) which would generate a great deal of data.

I had a number of responses from social workers in some Health Trusts and no responses from other areas. For example, there were no replies from AMHPs in Wales. Of course I will never fully know the reasons behind these differences. However, in the case of the area with the most responses, I noticed that the Lead AMHP had added a very encouraging preface to my request. It may be then that some of the gatekeepers did not pass on my message.

With an overwhelming number of potential participants, I needed to make decisions about how to select which social workers to interview. Aiming for a geographical

dispersion, I picked participants from Health Trusts all over England. Thus some were from metropolitan areas and others from more rural areas. Where there was more than one response from an area, I picked the second person who emailed. One email was from a whole team of AMHPs who had chosen to remain based separately from the rest of the mental health team. They all offered to be interviewed. I rang and spoke to the contact person and we agreed that a group interview would be the best way to proceed. Again this shows how research can take new directions.

### **1.11 Ethical (re)approval**

I decided to return to the College Research Ethics Panel to gain ethical approval for the group interview as my initial approval was only for individual interviews. This included devising additional information sheets and consent forms as there are added ethical considerations in a group interview. For example, the Information Sheet for the potential participants of the group interview had an extra section on confidentiality:

As this would be a group interview, it is important to recognise that your views would be heard by the other participants in the group. To enhance the confidentiality and anonymity of everyone in the focus group interview, I would ask everyone taking part not to repeat any information shared during the interview with anyone outside the group. This requirement is included in the Consent Form.

### **1.12 Consent**

I had email dialogue with all of the potential participants and sent each person a copy of the Consent Form in case that generated any questions. While a few asked questions about the research, surprisingly (to me) most just agreed to be interviewed. We arranged to meet at times and places that suited them. Hammersley and Atkinson (2007 p.116) stated that for many people, 'interviewing them on their own territory, and allowing them to organize the context the way they wish, is the best strategy'. I did not visit any of the participants at their homes and so

did not need to ask for their address. There were thirteen individual interviews (7 men and 6 women) and one group interview with five participants (2 men and 3 women). A total of seventeen people were interviewed.

At the start of each interview, the social workers were asked if they had any questions and then were asked to sign the Consent Form before the interview began. All the participants agreed for the interview to be audio-taped. The shortest interview was 90 minutes and the longest was 130 minutes.

### **1.13 The interviews**

There were only two set questions in the interview schedule as my goal was to generate narratives. The first interview question was to ask when the person first thought about becoming a social worker and the last question asked how they saw the future of mental health social work. This was an attempt to enable the social workers to complete a narrative arc from the beginning of their social work story to the future. In between these two questions, I responded to the stories and subjects raised by the social worker, asking questions that led from their answers. I had areas in mind that I wanted to cover – such as the introduction of the AMHP role – but often the social worker introduced these topics without my having to ask.

The social workers produced very lengthy replies to my questions and comments. They introduced subjects that I had never thought about and their answers were replete with narratives. I found it strange but exciting that I would travel to unfamiliar places to meet these unknown people where we would talk intensely before I left, never to see them again. Rather than being in any way awkward, there was an instant rapport between us. At the start of the interviews, the interviewees tended to ask about where I had worked and I saw this as them testing my authenticity as a social worker. Beynon (1983 p.41) described how he ‘unashamedly employed’ his shared occupational background in establishing rapport.

Social workers would be part of the group of people 'of whom one might say that talk is their business' (Hammersley and Atkinson 2007 p.116). Indeed, all of the social workers were articulate and eloquent. There were no uncomfortable pauses or silences in the interviews. However, it was not until transcribing the interviews that I noticed or reflected on this. In social work practice, social workers are used to being the interviewer, the person asking the questions and directing the talk. This may explain why I felt very comfortable in the interview role. Scourfield (2001 p.60) has written about 'interviewing interviewers' and argued that research 'mirrors social work practice in many respects'. For social workers, then, being 'interviewed' in social work practice happens rarely. However, this change of role did not seem to be difficult for the social workers. In fact, many expressed their enjoyment of the process.

#### **1.14 Transcription and stories**

Listening very closely and repeatedly to the words of the social workers during transcription I began to notice something strange. The interviews contained lots of shared laughter in response to the stories the social workers told about other members of the Community Mental Health team. In the interview situation, these stories had seemed to me to show the 'natural' order of things. However, repeatedly listening to the talk and seeing the words written out on the page created a sort of 'distance' where I began to see that these stories had a function or a purpose. It dawned on me that these were atrocity stories (Stimson and Webb 1975; Dingwall 1977; Baruch 1981; Allen 2001). Atrocity stories are a form of story-telling where other people are presented as somewhat lacking, stupid, or misguided. In contrast, the teller is presented as rational, sensible and morally adequate. The stories are vivid, detailed and often humorous and can be seen as 'moral tales'. Once I had noticed the use of atrocity stories I began to notice other elements of the transcripts as if I were seeing them for the first time. I remembered analysing the article 'K is mentally ill' by Dorothy Smith (1978) during a module on the MRes. The article is an analysis of an interview with 'Angela' in which she tells the story of how K comes to

be defined by her friends as mentally ill. Smith demonstrated how devices such as contrast structures and being described as a direct witness are ways in which the narrator's version of events is 'authorised'. Once this process of seeing what had previously been taken for granted and invisible to me had begun it was as if I could not stop. I noticed the ways in which the speaker authorised his or her version of events and how contrast structures were used to distinguish social work from other professions. I began to see the part that I played in the interview through my responses, laughter, and co-narration. I noticed how much was left unspoken. This was extremely disconcerting. I felt destabilised and confused. What I had thought to be 'business as usual' was revealed as something more complex. Again, I remembered an essay that I had written on the MRes about ethnomethodology. I returned to the lecture notes and for the first time, an approach seemed to fit perfectly with my data.

### **1.15 Ethnomethodology**

Ethnomethodology (EM) was devised by Harold Garfinkel [1917-2011]. Garfinkel was highly influenced by the work of Alfred Schutz [1899-1959] who modified and redefined the philosophical phenomenology of Edmund Husserl [1859-1938]. Garfinkel created the name ethnomethodology in 1954 and went on to write a series of papers over a twelve year period which were published in his 1967 book, *Studies in Ethnomethodology*. Anne Warfield Rawls (2002 p.6) clarified the meaning of ethnomethodology by breaking it down into three parts:

- 'ethno' refers to members of a social scene.
- 'methods' refers to the things that members routinely do to create and recreate the various mutually recognisable social actions or social practices.
- 'ology' means the study of these methods.

So ethnomethodology is the study of the methods that members use to produce mutually recognisable social interaction. Ethnomethodology originated from the

period that Garfinkel spent as Talcott Parsons' graduate student at Harvard. Garfinkel rejected Parsons' view that shared, internalised values and norms form the basis of social order in society. He also disagreed with Emile Durkheim's notion of 'social facts' as external to, and constraining of the actions of individuals in society. Garfinkel believed that these approaches treated members of society as 'cultural dopes' (1967 p.68). In ethnomethodology, social facts are seen as being produced in and through members' practical activities and are treated as *accomplishments*. For Garfinkel (1988 p.103) sociology's 'fundamental phenomenon' is the 'objective reality of social facts... being everywhere, always, only, exactly and entirely members' work, with no time out'. So whereas classical sociology is concerned with explaining social facts, ethnomethodology is focused on:

...the objective reality of social facts as an ongoing accomplishment of the concerted activities of daily life, with the ordinary, artful ways of that accomplishment being by members known, used, and taken for granted. (Garfinkel 1967 p.vii)

In ethnomethodology, social facts are seen as being produced in and through members' practical activities ['social facts as an ongoing accomplishment']. The focus is on the work that members do in their everyday interaction ['the concerted activities of daily life'] through the use of seen but unnoticed competencies of members ['known, used, and taken for granted']. In this way ethnomethodology is 'incommensurable' with classic or 'formal' sociology (Garfinkel and Wieder 1992). Ethnomethodology is concerned with 'sociology's epiphenomenon' (Lynch 2012 p.224). Therefore, the aim of ethnomethodological studies is to examine concrete witnessable and thus empirical data but with no concern as whether these are 'true' or 'real' ['the objective reality'].

John Heritage, a key ethnomethodological scholar, has described Garfinkel's writings as 'highly compressed and at times, opaque and cryptic' (1987 p.224). Interestingly, Garfinkel could write very well indeed. His short story, *Color Trouble*, was published in *The Best Short Stories 1941* (Garfinkel 1940; Doubt 1989). Garfinkel used difficult language because he was trying to describe only the concrete details of the research

encounter. He felt that conceptual or theoretical accounts or using generalisations to explain things obscured what was actually happening (Rawls 2002). He therefore invented new words and phrases in order to accurately convey what he witnessed.

### **1.15.1 An emphasis on interaction practices**

The individual is not the focus of ethnomethodology. Instead the focus is on a detailed study of witnessable shared enacted *interaction*. The interaction involves 'work' between members to accomplish a mutually intelligible orderly world. Ethnomethodology does not specify a particular research approach but the method must preserve the details of the social interaction over its course.

### **1.15.2 Ethnomethodology and identity**

In ethnomethodology identity is not seen as a possession of an individual but as belonging to situated practices. As such, ethnomethodology is not concerned with inner thoughts, feelings or emotions. As Garfinkel (1963) stated:

...there is no reason to look under the skull since nothing of interest is to be found there except brains. The 'skin' of a person will be left intact. Instead questions will be confined to the operations that can be performed upon events that are "scenic" to the person. (Garfinkel 1963 p.190)

Here 'scenic' means that which is directly observable. Identity is seen as an accomplishment; it is 'locally situated and occasioned in talk rather than simply a set of attributes brought to an encounter' (Taylor and White 2000 p.101). Thus, identity is seen as accomplished over the on-going and contingent interaction.

Garfinkel (2006 p.67) depicted identity as 'a symbolic object'; in other words, it has meaning, not existence. For Garfinkel (2006 p.68), identity 'has meaning, is meant, and, as such, is a property not of persons but of situated enacted practices in details'. Garfinkel (2006) discussed the guard at Widener Library on the Harvard campus and argued that the 'world of the guard is not an object of his thought, but



is a field of things to be manipulated, dominated, changed, examined, tested'. Rawls (2006) explained that:

The guard has routines, practices, in which he and others regularly engage, and it is these practices, the way in which people engage in them, and the time frame they produce through these activities that construct for the guard an identity. The successful achievement of this identity allows the guard's work – his enactment of practice – to assume a *taken-for-granted* character. (Rawls 2006 p.23)

In my research interviews I am asking the participants to 'speak as a social worker' and so they are required to demonstrate that they are a competent member of this profession. Thus, interviews can be seen as 'deeply moral events' (ten Have 2004 p.57). Ten Have (2004 p.70) showed how 'the *moral* standing of both participants is continuously at stake...they unceasingly watch and manage their own and their partner's standing as a careful and sensitive interactants. In ethnomethodological terms we both work to make 'doing being a social worker' recognisable, reportable, and observable through our talk. Thus, an individual is seen as having a 'situated identity' whose 'personal characteristics are of interest only insofar as they impact on their competence to produce the practices required/expected to enact their identity in the situation' (Rawls 2006 p.19). Thus Garfinkel (2006) warned that:

Therefore, researchers must avoid treating identity as a real object: It must be treated as a symbolic meaning /object, which has meaning, not existence, and whose construction takes constant care and must be explained as a configuration of interpretational and presentational procedures, not as motivational values. (Garfinkel 2006 p.71)

The emphasis is on how identity is 'meant' and accomplished in an on-going interaction.

### **1.15.3 The notion of member**

For ethnomethodologists, the notion of member is 'the heart of the matter' (Garfinkel and Sacks 1970 p.342). The focus is on the competencies involved in being

a 'bona-fide' member of a collectivity (ten Have 2007 p.140), how people accomplish sense-making in everyday life:

To become a member is to become affiliated to a group, to an institution, which requests the progressive mastery of the common institutional language...Once they are affiliated, the members do not have to think about what they are doing... having embodied the ethnomethods of a particular group, "naturally" exhibits the social competence that affiliates her with this group, allowing her to be recognized and accepted. (Coulon 1995 p.27)

Members of specialised groups are 'cultural colleagues' (Garfinkel 1967 p.11) who learn to produce recognisable social orders and do not see what is taken for granted. Garfinkel and Sacks (1970 p.342) showed how the accomplishment necessarily involves 'work' in order that it be sustained as an ongoing course of action.

#### **1.15.4 'She's such a social worker' and 'she's so not a social worker'**

Ethnomethodology focuses on the methods ('practical sociological reasoning') that people use to enable them to recognise each other as belonging to the same group. Key for my research is that:

*X is a group member, not on the basis of the portrayal of his mode of "internal activity", but rather is a group member on the basis of the treatment that is paid to him by Y...If Y treats X as a group member, then X is a group member. (Garfinkel 2006 p.197, emphasis in original)*

Thus, a person is considered to be a social worker if he or she is recognised by someone else as being able to successfully accomplish this situated identity in an interaction. In this way identity depends on the response of the other (Garfinkel 2006 p.60). Thus, the library guard is a library guard 'because he treats another person as a book-borrower' (Garfinkel 2006 p.171). This directly relates to the original question that had always puzzled me, the question that I had thought was too bizarre and non-academic to ask: namely, when I met other social workers, why was it that I thought '*she's such a social worker*' or, conversely, '*she's so not a social*

*worker*? In ethnomethodological terms, I recognise that person as a social worker because he or she is able to successfully accomplish this situated identity in the interaction with me, a group member. In the words of Rawls (2006 p.44), the 'question of membership is settled if the others are satisfied that commitment to the situated practices is ongoing'. Crucially, then, the interviews can be seen as two social workers accomplishing a situated social work identity in an interaction. Instead of playing the 'detached' or 'neutral' role of interviewer, I 'naturally' exhibit the social competence that affiliates me with social work. In his first lecture 1 in Spring 1970 Harvey Sacks discussed doing 'being ordinary'. Sacks expounded his 'central' assertions in the lecture:

Whatever we may think about what it is to be an ordinary person in the world, an initial shift is not to think of an 'ordinary person' as some person, but as somebody having as their job, as their constant preoccupation, doing 'being ordinary'. It's not that somebody *is* ordinary, it's perhaps that that's what their business is. And it takes work, as any other business does. (Sacks 1990 p.216)

Thus, in the interviews our business was working at doing 'being social workers'.

### **1.15.5 Institutional talk**

One way that a situated identity is successfully achieved is through the use of institutional talk. Expertise is conveyed through the use of specialised vocabulary and technical language. In social work this might be using professional terms such as 'clustered'; references to legalisation such as 'a 136' [this refers to section 136 of the Mental Health Act 1983]; and abbreviations such as 'an AC' [an Approved Clinician]. Using 'we' and 'our' rather than 'I' displays the person's institutional membership of a collectivity rather than an individual identity. Another type of institutional talk is the use of atrocity stories (Stimson and Webb 1975; Dingwall 1977; Baruch 1981; Allen 2001). From an ethnomethodological perspective, the 'truth' or 'reality' of these stories is not of any concern. Instead, the stories are a way of delineating what social work is not and function as an attempt to establish a boundary between social

work and other professions. Telling such stories to me in our interview displays that the participants saw me as a competent member. That I accepted these stories as somehow obvious and self-evident demonstrates the mutually recognisable and the taken for granted nature of our shared social work social practices. The point made by Taylor and White (2000) is pertinent here:

When professionals talk to each other, these forms of knowledge or tacit understandings are often displayed. They provide the taken-for-granted components of practice. (Taylor and White 2000 p.121)

The aim of ethnomethodological research is to make visible the taken-for-granted, or what Garfinkel calls the 'seen but unnoticed'. In Garfinkel's early studies he did this by 'troubling' the taken for granted aspects of social interaction by use of what he called 'breaching experiments'. Garfinkel (1967 p.38) described these as 'demonstrations designed...as aids to a sluggish imagination'. For example, Garfinkel asked his students to engage a friend in an ordinary conversation and then ask for clarification of a commonplace remark. Here is an example from Garfinkel (1967 p.44). S is the Subject and E is the Experimenter:

The victim waved his hand cheerily

(S) How are you?

(E) How am I in regard to what? My health, my finances, my school work, my peace of mind, my ...?

(S) (Red in the face and suddenly out of control.) Look! I was just trying to be polite. Frankly, I don't give a damn how you are?

Garfinkel thought that causing bewilderment and confusion could make explicit how everyday activities are ordinarily produced. For me, starting to see the commonplace and unnoticed in relation to social work was a like a form of breaching and left me feeling bewildered and confused.

### 1.15.6 Unique adequacy

Where the research is focused on a group of people with more specialised practices, such as social workers, it is more difficult to become a competent member. Garfinkel and Wieder (1992) argued that in order for the analyst

... to recognize, or identify, or follow the development of, or describe phenomena of order\* in local production of coherent detail the analyst must be *vulgarly* competent in the local production and reflexively natural accountability of the phenomenon of order\* he is "studying". (Garfinkel and Wieder 1992 p.182)

This is the unique adequacy requirement to be a competent practitioner of whatever group of participants is being researched. Ethnomethodological researchers have become professional jazz musicians, worked for years in science laboratories, worked as truck drivers, and taken degrees in law and advanced maths (Rawls 2006). In a reversal of traditional research methods, what would be considered 'subjective' is seen as necessary and a detached observer is seen as missing everything (Rawls 2006 p.94). In his ethnography of a children and families social work team, Andrew Pithouse (1998 p.8) argued that 'creating a lengthy association with practitioners...is essential to gain access to rarely observed processes that only accepted members of an occupational setting can share in'. Pithouse (1998 p.4-5) concluded that 'social work is invisible...only those who are accustomed to the occupational experience can appreciate what it means to do social work'. Pithouse's ethnography can be seen as a form of what Garfinkel (2002 p.175) termed the '*weak use*' of unique adequacy. Here the researcher must become vulgarly competent in order to recognise, identify, and describe the local production in any setting. In the '*strong use*' of unique adequacy the researcher uses ethnomethodological indifference to focus solely on members' methods, of '*seeing how he spoke*' (Garfinkel 1967 p.29). Garfinkel defined ethnomethodological indifference as:

...an indifference to the policies and methods of formal analysis...It is a procedure of not *needing* to consult the corpus of classic methods and findings with which to carry out the tasks of ethnomethodological research (Garfinkel 2002 p.170)

Therefore the researcher does not *need* to import concepts or analytical techniques of 'professional sociology' to understand the data. Rather it is already there in the accomplishment of the members 'just and only in any actual case' (Garfinkel 2002 p.191). Garfinkel and Wieder (1992 p.203) explained that ethnomethodological studies 'were looking for haecceities, just thisness; just here, just now, with just what is at hand, with just who is here, in just the time that this local gang of us have'. In addition, ethnomethodological indifference involves the researcher abstaining from 'all judgements of their adequacy, value, importance, necessity, practicality, success or consequentiality' of the accounts of members (Garfinkel and Sacks 1970 p.166).

My research uses both the weak and the strong forms of unique adequacy. I am uniquely adequate in the weak sense as I am vulgarly competent and so am able to accomplish, recognise, identify, and describe how social work is produced within the interview setting. In the findings sections I aim to use unique adequacy in the strong sense in my approach to analysis; this consists of working 'in such a fashion as specifically and deliberately, over actual exigencies of the research' (Garfinkel 2002 p.171). Therefore long extracts from the interviews are given, including my questions. I also aim to meet the definition of EM indifference produced by Garfinkel and Sacks (1970) in that an attempt is made not to judge the adequacy, importance or necessity of the accounts of the social workers. Being uniquely adequate in the weak sense means that I do not need to 'import' any information in order to understand, recognise or describe the ongoing accomplishment of social work in the interviews. Indeed, I was intimately involved in the on-going accomplishment of social work in the interviews. However, in terms of Garfinkel's (2002) later definition of ethnomethodological indifference, I do import 'classic' findings in order to analyse the interview data. For example, I use the findings of conversation analysts to

explore the use of laughter. In this way my research does not meet the unique adequacy requirement in the strong use.

Unique adequacy may be seen as a controversial concept. It can be seen as part of what Styles (1979) called insider and outsider myths:

In essence, outsider myths assert that only outsiders can conduct valid research on a given group; only outsiders, it is held, possess the needed objectivity and emotional distance... insider myths assert that only insiders are capable of doing valid research in a particular group and that all outsiders are inherently incapable of appreciating the true character of the group's life... They are elements in a moral rhetoric that claims exclusive research legitimacy for a particular group. (Styles 1979 p.148)

There are arguably also many similarities between the weak sense of unique adequacy and the notion of becoming an insider as a prerequisite to undertaking ethnographic research. For me, the difference lies in the way that the findings of the research are reported. Garfinkel is resolute that the focus of research should always be on *members' methods*; namely, to 'discover the things that persons in particular situations *do*, the methods *they* use, to create the patterned orderliness of social life' (Rawls 2002 p.6). In contrast, the findings of ethnographic research present an overview of a setting as if they are somehow standing above or outside of that setting. Here, there is a sense that the researchers have a greater understanding of the setting than the members do. I use both the ethnomethodological and the ethnographic stances to analyse and present my findings. I do acknowledge that unique adequacy cannot and should not be a prerequisite for all research. However, being a social work insider has undoubtedly played a central part in the process of this research. It is important to acknowledge that unique adequacy is fundamental to ethnomethodology. Indeed, it is this insistence on unique adequacy in both the weak and the strong uses of the requirement that makes ethnomethodology so distinctive.

### 1.15.7 The documentary method of interpretation

The documentary method of interpretation is another important ethnomethodological concept which is highly relevant to my research. Originally developed by Karl Mannheim (1952), Garfinkel (1967) described it thus:

The method consists of treating an actual appearance as “the document of”, as “pointing to”, as “standing on behalf of” a presupposed underlying pattern. Not only is the underlying pattern derived from its individual documentary evidences, but the individual documentary evidences, in their turn, are interpreted on the basis of “what is known” about the underlying pattern. Each is used to elaborate the other. (Garfinkel 1967 p.78)

Garfinkel (1967) discussed an experiment that he set up with a ‘counsellor’. Ten students told their personal problems to an experimenter purporting to be a student counsellor via an intercom. The students were asked to describe the background to their problem and then ask the ‘counsellor’ a series of questions to which they would be given a ‘yes’ or ‘no’ answer. In fact, these answers had already been randomly assigned and each student received exactly the same series of yes and no answers. Following each answer, the intercom was turned off and the student was asked to reflect on the answer. The students all made sense of the answers that they were given. Garfinkel (1967 p.93) concluded that in their capacity as members, the students ‘presupposed known-in-common features of the collectivity as a body of common sense knowledge subscribed to by both’.

In another experiment, Garfinkel asked his students to write down an actual conversation and then to describe what the participants understood they were talking about. Here is part of one such conversation:

Husband: Dana succeeded in putting a penny in a parking meter today without being picked up

Wife: Did you take him to the record store?



Husband: No, to the shoe repair shop.

Garfinkel (1967 p.39-40) explained that:

- (a) There were many matters that the partners understood they were talking about that they did not mention.

For example, the husband did not have to mention that he had picked up their four year old son Dana from nursery and that Dana had previously needed to be lifted up to put the penny in the parking meter.

- (b) Many matters that the partners understood were understood on the basis not only of what was actually said but what was left unspoken.

For example, the wife's question shows that she knew that her husband had stopped at the record store, but was asking if he had gone there before he had picked Dana up, or with Dana after he was picked up from nursery.

- (c) Many matters were understood through a process of attending to the temporal series of utterances as documentary evidences of a developing conversation rather than as a string of terms.

For example, the husband's answer shows that he recognised the question implicitly asked by his wife – he stopped at the record store before he picked up Dana but stopped at the shoe repair shop after he had picked Dana up. The parking meter was outside the shoe repair shop.

- (d) Matters that the two understood in common were understood only in and through a course of understanding work that consisted of treating an actual linguistic event as "the document of", "as pointing to", as standing on behalf of an underlying pattern of matters that each already supposed to be the matters that the person, by his speaking, could be telling the other about.

This conversation is the documentary method of interpretation in action.

- (e) In attending to the utterances as events-in-the conversation each party made reference to the biography and prospects of the present

interaction which each used and attributed to the other as a common scheme of interpretation and expression.

For example, both knew that previously Dana had not been able to reach the meter independently.

- (f) Each waited for something more to be said in order to hear what had previously been talked about, and each seemed willing to wait.

For example, through the mention of the parking meter, the wife recognised that the husband and Dana had stopped somewhere but it was only through the unfolding interaction that she understood that this had been at the shoe repair shop.

In relation to my interviews, the documentary method of interpretation shows that much can be left unsaid when the speakers each assume that both share a common scheme of interpretation and expression. There are numerous examples from the interview data and these will be highlighted in the findings chapters.

### **1.15.8 Indexicality**

Another core ethnomethodological concept is 'indexicality'. Indexicality points to the 'essential incompleteness' of language (Garfinkel 1967 p.29) as the meaning is intrinsically linked to the context in which it is said. The 'transient circumstances of its use assure it a definiteness of sense...to someone who knows how to hear it' (Garfinkel and Sacks 1970 p.161). Consider the following exchange from my interview data:

Ed: you know brown?

Lisa: Yes, yeah.

Here we are not talking about the colour brown. Rather, Ed is referring to a book by Robert Brown, *The Approved Mental Health Professional's Guide to Mental Health Law*. Ed does not have to elaborate here. He pre-supposes that I share this known-

in-common feature of the social work collectivity because of my biography as a mental health social worker. My reply demonstrates that we do both subscribe to this body of common sense knowledge. Again, there are numerous examples of indexical expressions within my data which will be highlighted in the findings chapters.

### **1.15.9 Naturally occurring data? Ethnomethodology and interviews**

Ethnomethodological research has tended to concentrate on ‘naturally occurring’ data and has rarely used interviewing as a source of data. However, there is a growing body of ethnomethodological writing on interview talk. The work of some of these writers will be discussed in this section.

Tim Rapley’s (2001) focus is on interviews as inherently sites of social interaction which should be studied as such. He cited Cicourel (1964) as starting the debate. Cicourel (1964 p.81) argued that studies of interviewing procedures and common-sense ‘rules’ of everyday life are ‘essentially studies on the same phenomena’ and that in interviewing:

We find that continuous situational imputations, strategies, and the like occur which influence how actors treat each other and manage their presence before each other...Now *these are precisely the conditions found in everyday life*. (Cicourel 1964 p.87 emphasis mine)

Rapley (2001) demonstrated how interviewees’ talk speaks to and emerges from the wider strategies and repertoires available to, and used by, all people. However, the interview data are ‘highly dependent on and emerge from the specific local interactional context and this local interactional context is produced in and through the talk and concomitant identity work of the interviewer and interviewee’ (Rapley 2001 p.317). Here the interviewer and the interviewee are seen as *both* actively producing the interview-as-interaction through their talk. Thus, the contribution that we both make in accomplishing the interaction as a research interview is examined throughout the findings chapters, in particular in Chapters 7 and 8.

Carolyn Baker (2003; 2004) has written about a number of ways that ethnomethodological ideas can be applied to the analysis of interview data. Baker (2003) identified some of the key points relating to the ethnomethodological approach to the analysis of interview data: the interview is seen as a conversational interaction; both the interviewer and the interviewee engage in work in making the interview happen *as an interview*; and the interviewer's questions and the interviewee's answers are treated as 'sense-making work'. Baker (2003) argued that the interviewer selects participants on the basis of their membership of a specific category, for example, a social worker. The participant must then account for themselves as a competent member of this category. The interviewer and interviewee are both engaged in 'putting together a world that is recognizably familiar, orderly and moral' (Baker 2004 p.178).

Stephen Hester and David Francis (1994) demonstrated how the actual work of accomplishing an interview is rendered invisible in traditional sociological studies. In their paper, Hester and Francis (1994) analysed one interview to display the interview as mundane practice and as a locally accomplished event. They demonstrated the haecceity, the 'just thisness' (Garfinkel and Wieder 1992 p.203) of the research interview by describing the accomplishment of the interview 'as it is interactionally and collaboratively achieved by the interviewer and interviewee *in this case*' (Hester and Francis 1994 p.681).

### **1.16 Respecifying my research question**

Therefore, in ethnomethodological terms, my research question became about 'doing being a social worker'.

How do social workers manage to successfully accomplish a social work identity? Specifically, how do they accomplish a social work identity in their interviews with me, also a social worker?

Sue White (1997 p.79) explained that she was 'convinced that the reproduction of the 'natural' social work attitude was facilitated by my collegial status'. Being a vulgarly competent member allows for the taken for granted components to be displayed in our interaction.

I aim to make visible what it is to be a vulgarly competent social worker. However the difficulty for me is that as a social work insider, I struggle to see the wood for the trees. It is a painstaking process and somewhat disconcerting and destabilising to be able to critically analyse social practices which to me seem the 'right' way, if not 'only' way of being in the world. This feeling was experienced by White (1997 p.88) in her ethnography of a children and families team. White described starting to take notes from the case files: 'the natural attitude had taken over and all I could see was 'ordinary' and highly predictable case recording'. Like me, it was only during transcription that she began to see patterns and routines emerging. Equally, Pithouse (1984) described:

To begin with, any initial surprise the setting held for me was the 'shock' of not knowing what to observe, what to read and what to 'do' next. Secondly, as someone who had trained as a social worker I found the setting not altogether strange or uncomfortable. It was just 'like any other social work office' I had trained in. People were writing, talking, answering phones, coming and going. What could possibly be of real interest in this? (Pithouse 1984 p.24)

Reading the work of Sue White and Andrew Pithouse was extremely helpful and reassuring. What I found very interesting is that these were both ethnographies of social work. Managing familiarity is an integral part of ethnography and discussed at length in books and articles about this approach. It is not discussed in the standard interview literature where the discussion is about being 'neutral' (or not, as in some feminist research; for example Oakley 2000; Harding 1991) and establishing 'rapport'.

The work of the phenomenologist Alfred Schutz is also relevant here. As stated earlier, Garfinkel drew upon the work of Schutz in developing ethnomethodology. In

his article 'On Multiple Realities', Schutz (1945) discussed the concept of the 'natural attitude' of daily life. Here 'the wide-awake, grown-up' person is construed as acting in and upon an inter-subjective world where reality is seen as natural. For Schutz, people have a pragmatic and practical approach to the world, taking the world for granted with no reason to doubt that that things are 'as they really are'. Schutz named this the 'epoché of the natural attitude':

He does not suspend belief in the outer world and its objects but on the contrary: he suspends doubt in its existence. What he puts in brackets is the doubt that the world and its objects might be otherwise than it appears to him. (Schutz 1945 p.564)

It is only when people experience something 'strange' or a 'specific shock' that they are compelled to revise their view of reality. For me, doing being a social worker was the 'natural attitude'. I did not question or doubt this view of the world. It was during transcription of the interviews that I began to notice something strange. Paying close attention to what was said in the interaction allowed me to 'see' what was formerly invisible. The view of the world that I had taken for granted was disrupted.

### **1.17 Managing familiarity**

An ethnographer is typically a 'marginal native' (Hammersley and Atkinson 2007 p.89). Thus, the ethnographer enters the setting as an outsider and aims to become familiar with the culture in order to develop understanding. Pithouse (1984 p.30), for example, described how he saw his role during his fieldwork in a social service department as 'participant as observer' and reminded his participants that 'I was not a practitioner but wished, in so many words, to be seen as an 'acceptable incompetent''. However, the ethnographer is advised not to become too enmeshed within the culture and go 'native' (Gold 1958). Hammersley and Atkinson (2007) explained that:

The comfortable sense of being 'at home' is a danger signal. From the perspective of the 'marginal' reflexive ethnographer, there can thus be no question of total commitment, 'surrender', or 'becoming'. There must always remain some part held back, some social and intellectual 'distance'. For it is in the space created by this distance that the analytic work of the ethnographer gets done. (Hammersley and Atkinson 2007 p.90)

### **1.18 Going native? A native becoming marginal**

I was not a 'native' or a 'complete participant' (Gold 1958) because this was not covert research or an ethnography conducted in a social work setting where I was employed. However, I was not a marginal native in the usual sense because I did not have to learn how to accomplish social work. Unlike an ethnographer who becomes marginal by moving from the outside in, I became marginal by moving from the inside out. Thus, where Pithouse (1984 p.31) endeavoured to remain a 'friendly stranger' in order 'to note the processes of interaction rather than intimately engaging in their construction', I was intimately engaged in the accomplishment of a social work identity in the interview as interaction. Like White, I went through the *reverse* during the research process, becoming aware of the taken for granted nature of doing being a social worker. Becoming a 'marginal native' was not something that I had envisaged or planned for as I would have done had I been undertaking ethnography. Instead it was an unexpected outcome of the research process. In addition, an ethnographer is only marginal during fieldwork; I had become a marginal native to my profession. My social work identity had been fundamentally changed through the research. I no longer hold the 'natural attitude' and am unable to read social work texts without being able to see the artful ways in which social work is accomplished in mundane and routine ways.

### **1.19 My 'dirty secret'**

I had always been uncomfortable with the idea of getting a PhD off the back of my participants. This is precisely why I chose not to research service users who

experience mental distress. I felt that social workers had enough awareness of the research process in order to make an informed decision about participating in the project. However, once I was transcribing the interviews, I became increasingly guilty at the way I was subjecting the words of the social workers [and my own – but this did not make me feel guilty - rather it made me feel embarrassed] to critical analysis. I felt anxious and sick, like I had a 'dirty secret' that I could not discuss with anyone. These feelings intensified the first time I used extracts from the interviews during a talk at a neighbouring university. Speaking the words of the social workers out loud in a room full of mental health academics, service users and practitioners, I felt that, not only was I using their words to further my academic career, but also that I was betraying the social workers by opening them up to scrutiny to people they had never met. As a registered social worker, I felt extremely uncomfortable in allowing the social workers to be criticised by the room of 'strangers'. I felt physically sick and ashamed. These feelings remained with me for the next few weeks. I could not proceed with the data analysis. I decided that I would just write an 'emotionalist' account of the interviews after all. However, I found that it was not possible to do this either because I could not stop 'seeing' the accomplishment within the interview interaction. Not knowing how to proceed, I sent an email to a social work academic who was the only person that I knew of who had discussed this issue in their thesis. I wrote:

I am really struggling with being critical of the AMHPs who so kindly agreed to be interviewed by me and somehow feel that I am 'betraying' them and social work.

I was overwhelmed at the kindness and support of this academic who spoke to me at length on the telephone and helped me devise strategies for how to proceed with the research. Able to move forward, once again I turned to reading about ethnography. Hammersley and Atkinson (2007) described how:

Marginality is not an easy position to maintain, however, because it engenders a continual sense of insecurity... many fieldworkers report



that they experience some degree of discomfort by virtue of their 'odd', 'strange', or 'marginal' position. (Hammersley and Atkinson 2007 p.89)

They continue:

...the stress experienced by the 'marginal native' is a very common aspect of ethnography, and it is an important one. In so far as he or she resists over-identification or surrender to hosts, then it is likely that there will be a corresponding sense of betrayal, or at least of divided loyalties (Hammersley and Atkinson 2007 p.90)

However, rather than experiencing this stress and insecurity during the research process, I experienced them in my life outside of the research setting. I found it very interesting to read the following excerpt from Pithouse (1984):

As the project progressed, I found it all too comfortable to identify empathically with the members for the instrumental reason of gathering information that was not usually available for those outside the colleague group. Of course the purpose was to gather data but the use of relationships to probe and glean information became both routine but disagreeable. The feeling of spy and agent-provocateur... (Pithouse 1984 p.33)

Here the more 'routine' that it became for Pithouse to gather data, the more 'disagreeable' it became. In other words, the more that he became part of the social work culture (i.e. it was routine and not strange), the more difficult it became on an emotional level (feeling like a spy and agent provocateur). For me it was the other way round. I began quite happily, feeling that it was routine, and it only became disagreeable as it became more unfamiliar.

The two pieces of writing that helped me to feel at least some sort of 'resolution' to the problem of my dirty secret were again by Pithouse and White. In his doctoral thesis, Pithouse (1984) maintained:

...the research neither seeks to defend or injure the interests of those who gave their trust and confidence in order that the project could be realised. (Pithouse 1984 p.7)

In her doctoral thesis, White (1997) contended:

I can only reiterate that my intention is not to *judge* social workers, but to *describe* their ways of doing and creating 'business as usual', and to illustrate through transcripts the local production of knowledge and meaning. (White 1997 p.95)

These two statements sum up my intention in this thesis. I do not wish to judge or injure the social workers who gave me their trust and confidence. My intention is to describe the ways in which they – and, just as significantly, I - do being social workers in the interview as interaction.

## **1.20 The value of ethnomethodology for social work**

Despite the bewilderment, stress and anxiety I have experienced during the research process, using ethnomethodology can be seen as increasing my skills and knowledge as a social worker. Social workers have the power to 'erase, silence, and rewrite client accounts using organizational and professional discourses' (de Montigny 2007 p.105). Taylor and White (2000 p.35) argued that all professionals working with service users need to undertake a process of 'epistemic reflexivity' whereby professionals subject their own knowledge claims to critical analysis. In this way dominant professional ideologies and the ways in which people are constructed as service users can be examined and challenged. Ethnomethodology is one way of achieving this reflexivity. The words of Rawls (2002) are relevant here:

Garfinkel asks us...to bring sociology from the realm of conceptual theorizing into the hands of practitioners, in order that we may understand and improve upon the both the quality of individual human experience and the possibility of providing high-quality lives for all human beings. Social change requires, first and foremost, an understanding of social processes (Rawls 2002 p.19)

## **1.21 The process of data analysis**

I began analysing the data with a close reading of the transcripts. Once I had completed this process for all of the transcripts, I felt that I 'knew' the interview data in a great deal of depth. I was able to ascertain several 'themes' in the talk of the social workers. An exposition of these themes are contained in part one of the findings chapters.

Following this, I took the advice of Hammersley and Atkinson (2007 p.169) to 'pay attention to *failed performances, unexpected outcomes or crises*'. For example, I noticed that there were two occasions concerning laughter which seemed unusual or unexpected. During the interview with John, I laughed at something that he said but he does not join in with my laughter. Andrew stated in his interview that 'I could laugh at it a lot of the time', but he did not laugh, and nor did I. I reflected on these and similar 'oddities' or apparent 'deviations'. These two occasions concerning laughter are discussed in more depth in the section on 'doing non-seriousness' in Chapter 7.

Next, I used ethnomethodological insights to analyse the atrocity stories. The process of analysis is a reflexive activity rather than a distinct stage of the research (Coffey and Atkinson 1996 p.6). I noticed that as I looked at a small piece of talk more closely, new analytical details started to emerge. This continued when I started to write. As I wrote up my analysis, I noticed even more of interest and began to recognise the ways in which my analysis linked with other published research.

## **1.22 Ordering the thesis and writing up**

For me, writing the thesis and deciding what to include and exclude was one of the most difficult part of the research process. I was overwhelmed with the amount of data and there were many possible forms that the thesis could take. I did not know how or where to start. I remained 'stuck' for many months, (ironically) avidly reading about writing. This impasse only ended at the beginning of the fourth year when my

new supervisor asked me to write something, anything, about the atrocity stories within my data. I still do not know exactly why, but once I started I could not stop writing and quickly produced three pieces of writing, all of which are included here. I finally understood that writing and analysis are inextricably linked. The act of writing created new ideas and thoughts. For me, discovering a love of writing has been one of the most surprising outcomes of the research process. Ordering the thesis became a creative process as it was only through the writing that I was able to make decisions on what to include or in what form as 'our writing is inescapably implicated in how we reconstruct the social worlds we have researched' (Coffey and Atkinson 1996 p.193).

### **1.22.1 Writing: Ethnomethodological or Ethnographic?**

I found it seemed 'natural' to write using ethnomethodological insights and all the first pieces of writing used this approach. This involved examining *how* social work identity was accomplished *within the interview as interaction*. However, I also wanted to do justice to the issues and themes that the social workers spoke about in the interviews. To ignore these felt uncomfortable but at the same time I was aware that this was a very different type of writing; a more ethnographic style. I struggled with how to present these two distinct styles of writing and analysis within the thesis and eventually decided to divide the findings section into two parts. Initially I decided to start with the ethnomethodological sections, to be followed by the sections using a more ethnographic writing style. However, my supervisor advised me to read the book by D. Lawrence Wieder (1974) about the case of telling the 'convict code'. Wieder divided his findings section in two parts. Part 1 presents an ethnography of the setting (the halfway house) in which the convict code emerged and Part 2 presents an ethnomethodological analysis of how the convict code worked and was used. Consequently, I reversed the initial order to follow Wieder's (1974) classic study.

### **1.22.2 Common-sense knowledge as an inevitable resource**

More recently, I have become aware that, like members, ethnomethodological researchers inevitably also rely on common sense knowledge. Common sense knowledge and ways of knowing constitute an 'unavoidably used resource, as well as the topic of inquiry' (ten Have 2004 p.37). To address this issue, Paul ten Have (2004 p.35) has suggested following the proposal of Roy Turner (1971). Turner proposed that ethnomethodological research should be undertaken in two phases. In the first part of the research, the researcher uses the knowledge that they have gained from being a competent member to recognise the activities that the participants in the interaction are engaged in. In the second part of the research, the researcher analyses this understanding from a procedural perspective (ten Have 2004 p.36). Turner (1971 p.177) concluded that 'sociological discoveries are ineluctably discoveries from within the society'. I hope that dividing my findings into two parts goes some way to meeting Turner's proposal.

### **1.23 Quality in qualitative research**

A fundamental and important aspect of any research project is establishing the quality of the research. This is equally as important in qualitative research as in quantitative research. However, determining the quality of a research project is not a straightforward or simple task. Clive Seale (1999, 1999a, 2007) has written extensively on the issue of quality in qualitative research and has concluded that it is a somewhat 'elusive' phenomenon (1999 p.7). He argued that social research should be seen as a craft occupation, informed by, but relatively autonomous from philosophical, political, or theoretical positions. Seale viewed these positions as a 'burden' and that allowing any one of them to over-determine the research process is mistaken. Instead, Seale (2007 p.380) advocated a practical and creative approach to honing research skills by engaging in an inner and outer dialogue during the research process. The outer dialogue concerns the external relations of a research project: namely, its relevance to practical and political projects, its consequences,

uses and overall purpose. The inner dialogue concerns the internal logic of the research such as the adequacy of links between claims and evidence. Seale argued that this can be enhanced by drawing on philosophy, social theory, and methodology. This inner and outer dialogue is continued in a dialogue with an external audience as part of a general commitment to fallibilistic, open-minded debate.

Seale (1999 p.157) advocates reflexive methodological accounting, where the researcher provides 'a fully reflexive account of procedures and methods, showing to readers in as much detail as possible the lines of inquiry that have led to particular conclusions'. I have attempted to do this in this methodology chapter. In addition, I concur with Seale's view that a researcher should continue to strive towards producing research of the highest quality by engaging in dialogue with other researchers. However, I do not agree with Seale that it is possible for researchers to operate independently from philosophical, political, or theoretical positions: whether they acknowledge it or not, all researchers operate from somewhere (Haraway 1988 p.590), there is no view from nowhere.

In the past (and in many cases, still today), positivist criteria such as validity, objectivity, and reliability were used to judge the quality of qualitative research. However, such criteria began to be contested with the rise of constructivist and critical theorist research. As a result of these debates about the importance of criteria such as validity, objectivity, and reliability, researchers working within the constructivist paradigm began to develop new criteria to judge the quality of research. In their book, *Naturalistic Inquiry* (1985), Yvonna Lincoln and Egon Guba made the first attempt within the constructivist paradigm to develop new non-foundational quality criteria. Guba and Lincoln termed these 'trustworthiness' criteria which could be used to judge both the process and outcomes of a research project. These parallel the positivist concerns of validity, objectivity, and reliability. The new criteria were credibility (paralleling internal validity), transferability (paralleling external validity), dependability (paralleling reliability), and

confirmability (paralleling objectivity). These were well received but Lincoln and Guba went on to view the way that they parallel positivist criteria made them 'suspect'. Whilst rejecting objectivity as a test of quality in research, Guba and Lincoln (2005) maintained that:

Validity cannot be dismissed simply because it points to a question that has to be answered in one way or another: Are these findings sufficiently authentic (isomorphic to some reality, trustworthy, related to the way others construct their social worlds) that I may trust myself in acting on their implications? More to the point, would I feel sufficiently secure about these findings to construct social policy or legislation based on them? (Guba and Lincoln 2005 p.205)

Thus, Guba and Lincoln developed new criteria which they term authenticity criteria, 'so called because we believed them to be hallmarks of authentic, trustworthy, rigorous, or "valid" constructivist or phenomenological inquiry' (Guba and Lincoln 2005 p.207). From this approach, authenticity is demonstrated if researchers can show that they have represented a range of different realities ('fairness'). Research should also help people develop increased understanding ('ontological authenticity'), allow people to see other viewpoints ('educative authenticity'), encourage change ('catalytic authenticity'), and to have empowered members to act ('tactical authenticity'). Catalytic authenticity and tactical authenticity can be seen a shift from interpretation and *Verstehen* towards a call for social action (Guba and Lincoln 2005 p.201). It means that the constructivist paradigm begins to resemble the critical theory and participatory research paradigms.

Guba and Lincoln's authenticity criteria are consistent with the ontological beliefs of the 'weak' constructivist paradigm: namely, that research accounts represent a sophisticated but temporary consensus of views about what is to be considered true. Seale (1999a p.470) pointed out that 'judgements about the plausibility of research accounts inevitably involve a temporary subscription to the view that language is referential to a reality outside the text'. Thus, a strong constructivist or postmodern view where the existence of any real world is denied means that the very issue of quality criteria is challenged. Those researchers working within a

'strong' constructivist paradigm do not believe that it is possible to distinguish between interpretations, or indeed that it is necessary to do so. This results in a radically sceptical and even nihilistic stance (Schwandt 2000 p.198). I do not concur with this approach. My social work background means I am not willing to accept a complete disbelief in 'reality' as some writers suggest. After all, as Fontana and Frey (2005 p.697) pointed out that the 'windmills of racism, sexism, and ageism are not mere shadows in our minds; rather they are very real and very oppressive'. My experience as a social work practitioner has given me a deep understanding of the extensive impact of very real constraints on the lives of vulnerable people. These include poverty, inadequate housing, and poor health. Kathy Charmaz, a constructivist grounded theorist, argued that researchers from this paradigm can hold the belief that social worlds exist outside the interview. This belief can be accepted 'without assuming the existence of a single, encompassing, obdurate reality' (Charmaz 1995 p.62). Charmaz noted that the chronically ill people she interviewed experience sickness regardless of whether or not they participate in her interviews. I agree with Miller and Glassner (2004 p.131) that 'narratives which emerge in interview contexts are situated in social worlds; they come out of worlds that exist outside of the interview itself'. Thus, my ontological beliefs mean that I adhere to a 'weak' constructivism.

Seale (1999) concluded that Guba and Lincoln's authenticity criteria substitute political goals as the criteria of good research and that this is 'frighteningly weak' (Seale 2007 p.379). However, all research is political to some degree. Although research is often presented in a way in which the researcher is invisible and anonymous, the author is 'a real historical individual with concrete and specific desires and interests' (Harding 1987 p.9). Therefore, it is important for researchers to explicitly acknowledge that their biographies will inevitably shape the research (although I do not think it is necessary to include a full 'confessional' as is found in some postmodern accounts). My social work identity has inevitably and indelibly shaped this research.



Hammersley (1991; 1992) has adopted a more 'subtle realism' and argued that knowledge should be defined as 'beliefs about whose validity we are reasonably confident' (1992 p.50) rather than know with certainty. He acknowledged that 'there can be multiple, non-contradictory and valid descriptions and explanations of the same phenomenon' (1992 p.51). Subtle realism retains the idea that there are independent and knowable phenomena but there is an acknowledgement that direct access is not possible as all knowledge is based on cultural assumptions and is a human construction. For Hammersley, knowledge claims must be assessed in terms of their 'plausibility' and 'credibility'. Hammersley (1991 p.61) defined plausibility as 'whether we judge it as very likely to be true given our existing knowledge'. Credibility is defined by Hammersley (1992 p.70) as 'whether it is of a kind that we could reasonably expect to be accurate, given what we know about the circumstances in which the research is carried out'. The researcher must provide sufficient evidence for the claim – and be prepared to supply further evidence if necessary. This can be seen as a form of the reflexive methodological accounting advocated by Seale (above).

### **1.23.1 Quality and the narrative approach**

The dialogical narrative approach means that verifying the facts is less important than understanding how the individual social workers use narratives to make sense of their experiences (Riessman 2002 p.704). Thus, the aim of narrative research is to try to understand how and why individual social workers construct their accounts rather than establishing whether their accounts are factually accurate. Riessman (2008) argued that researchers need to be explicit about the methodological decisions made and provide clear evidence for each of their claims. This can be achieved by including extended narratives and deviant cases, and by examining alternative interpretations. Again, this can be seen as a form of the reflexive methodological accounting advocated by Seale (above).

### **1.23.2 Quality and Ethnomethodology**

As stated above, an ethnomethodological approach is concerned with an examination of concrete witnessable and thus empirical data but with no concern as whether these are 'true' or 'real' ['the objective reality']. The interview is seen as an 'artefact' and the relationship to reality is not 'merely unknown but in some senses unknowable' (Dingwall 1997 p.56). However, the detailed transcripts produced in ethnomethodological analysis can be examined by others to assess the veracity of the analytic claims. Discussing his use of detailed transcripts, Sacks (1992 Vol. 1 p.622) pointed out that 'consequentially, others could look at what I had studied, and make of it what they could, if they wanted to be able to disagree with me'. This means that there is a public forum in which to assess the reliability of the data analysis included in any research report (Silverman 2006 p.361).

### **1.23.3 Assessing the quality of my work**

In line with the advice of Seale (1999) and Riessman (2008), the aim of this methodology chapter has been to explicate the methodological decisions made during this project. It is for this reason that I have deliberately used the first person throughout this chapter (and, indeed throughout much of the subsequent chapters). For me, the notion of an 'objective' account written in the third person is an attempt to create the idea of research as a linear and unimpeachable process. As Richardson (1997 p.18) made clear, 'science does have a human narrator, the camouflaged first person, hiding in the bramble of the passive voice'. It denies the messiness and difficulties that surely occur in every project. However, like all writers, I wish to persuade the reader of the veracity of my arguments and so my claims cannot be seen as somehow neutral.

In the subsequent chapters, lengthy extracts from my data are presented which retain and display the interview as an interactional accomplishment. By doing this, I hope that the reader will have enough material in order to make a judgement as to

the plausibility and credibility of my claims. Again, it would be disingenuous not to acknowledge that the materials have been selected by me from an array of possibilities. However, I have deliberately included analysis of several 'deviant' cases. Indeed, as Garfinkel (1967) made clear, these apparent anomalies or breaches can be a means of making visible the 'seen but unnoticed'.

## **1.24 Conclusion to chapter**

I hope that this 'natural history' of my research has achieved the aims outlined by David Silverman (2010) at the beginning of this chapter. I have attempted to explain the actual course of my decision making, including my responses to the various difficulties and dead ends experienced during the research. Serendipity, luck, and biography have all played an important part throughout the research. The process of undertaking this project has changed me in ways that I could not have imagined at the beginning of the research when I first walked into the Professor's office.

## 2 A review of the literature using qualitative narrative synthesis

### 2.1 The aim of the literature review

This review of the literature was undertaken at the very beginning of the project. At that time I was still searching for an appropriate methodology. I decided that an important starting point for my research would be to establish an overview of all the primary empirical research evidence relating to social work identity in interprofessional mental health teams since 1990. The rationale for this choice of time frame was that the Joint Health and Social Services Circular HC (90)23/LASSL(90)11 introduced the Care Programme Approach in 1990. This was the first piece of legislation to require collaborative working between health and social services in mental health services. Thus, the aim of the review was to establish a baseline for my project.

### 2.2 Systematic reviews and qualitative synthesis

This review of the literature is based on the systematic review approach developed by the Social Care Institute for Excellence (SCIE). Two main resources were used in guiding the review: the SCIE systematic research review guidelines (Rutter, Francis, Coren, and Fisher 2010) and the worked example of using qualitative research in systematic reviews by Fisher, Qureshi, Hardyman, and Homewood (2006).

The aim of a research review is 'to gather together systematically a comprehensive, transparent and replicable review of all the knowledge in a particular area' (Rutter et al. 2010 p.14). It is based on a meticulous, transparent and replicable approach to reviewing the literature. Unlike a traditional literature review, a systematic review is only based on primary empirical research evidence. Other forms of knowledge, such as policy and theory, are reported separately in the background section of the

review. This means that all the evidence in the review has already been subject to quality appraisal through the peer-review process of publication.

Systematic reviews are rare in social care and may be 'breaking new ground methodologically' (Rutter et al. 2010 p.14). Those that have been undertaken have tended to be based on quantitative controlled outcome studies (for a social work example, see Holden et al. 2010). A systematic review of quantitative controlled studies may use meta-analysis to synthesise the data. In this way, the results from several smaller studies can be statistically combined to produce more powerful and rigorous results. In a similar way a systematic review of research which is qualitative in nature (or which has qualitative components) can use 'qualitative narrative synthesis' to go beyond the individual studies to produce new understandings. For example, Campbell et al. (2003 p.682) found that their synthesis of lay experiences of diabetes and diabetes care resulted in 'a greater degree of insight and conceptual development than is likely to be achieved in a narrative literature review'.

## **2.3 The process of the qualitative synthesis**

### **2.3.1 Research protocol**

A draft research protocol was developed (see Appendix 1). The protocol sets out the search strategy to be used in the review. It lists the search terms, the databases to be searched, other forms of searches to be undertaken (e.g. author searching), and the inclusion / exclusion criteria. There are many terms used in the literature for what I have called 'interprofessional' working and these can have very similar meanings or be used interchangeably in the literature. These include: interprofessional; interagency; interdisciplinary; multidisciplinary; partnership; and multiprofessional. In addition, each of these can be written in up to three ways: for example, 'interprofessional', 'inter professional' and 'inter-professional'. All these possible combinations were used in the search. The draft protocol contained three criteria for inclusion. These were:

- Research undertaken in the UK
- Written in English
- Published from 1 January 1990 onwards

The draft protocol was tested using a scoping exercise. This exercise involved using the draft protocol to search one database, Swetswise. The scoping exercise highlighted some relevant empirical research undertaken outside the UK so this exclusion criterion was removed. The other two criteria remained the same.

### **2.3.2 Research protocol after scoping**

The new protocol (see Appendix 2) explicitly set out a 9 step search process to be followed. The terms used in the search remained as close as possible to the original protocol. However, database search engines differ. CINAHL, for example, has 'subject terms', Social Service Abstracts has KW (title, abstract; descriptors), while Scopus has TITLE-ABS-KEY (title, abstract; key words). Other databases use 'topic' (e.g. ISI Web of Knowledge) while others, particularly in the grey literature search, use free-text search terms. Holden et al. (2010 p.370) pointed out that the idiosyncratic ways in which some databases operate mean that there will always be a shred of doubt that some studies were missed.

## **2.4 The literature search**

For transparency, each step of the search process was recorded and is available at Appendix 3.

### **2.4.1 Stage 1: Initial search**

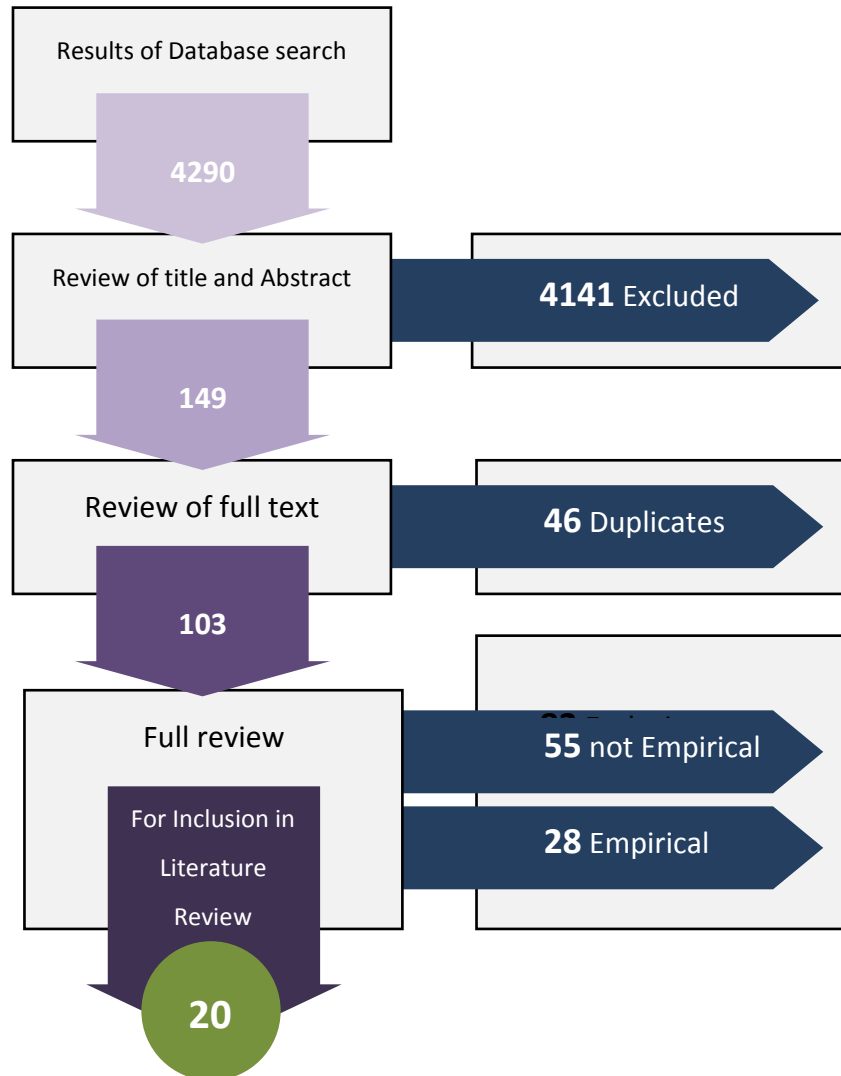
In the first stage of the search, articles retrieved from each database were excluded or included on the basis of the abstract. Where there was no abstract, or it was not clear from the abstract whether the article was relevant, the full-text was viewed

on-line. In this initial stage 4,290 resources were identified, 4,141 were excluded after a review of the abstract and 149 full-text articles were retrieved.

#### **2.4.2 Stage 2: Review of full-text articles**

The 149 full-text articles were then reviewed. Forty-six of these were identified as duplicates and thus excluded. One hundred and three articles remained. Each of these was then read in turn. Articles were excluded if they did not report original empirical research. For example, the article by Simpson et al. (2003) provided a critical overview of the development of the Care Programme Approach. Articles that reported empirical research were excluded if the research was not relevant to the focus of my thesis. To reiterate, this was empirical research evidence relating to social work identity in interprofessional mental health teams since 1990. The article by Huxley et al. (2008), for example, examined the decision-making by multi-disciplinary teams relating to eligibility criteria and thus there was no discussion of social work identity. A total of 83 articles were excluded. All the articles excluded at this stage and the reasons for exclusion are listed in a table in Appendix 4. This process of exclusion and inclusion is shown in a flow diagram below.

**Table One: Flow chart showing the process of inclusion and exclusion**



### **2.4.3 Stage 3: Data extraction from full-text articles**

A total of 20 articles were assessed as being directly relevant to the specific focus of my empirical research. Each of these was then made subject to a data extraction process using the template devised by Fisher et al. (2006). Qualitative narrative synthesis requires reviewers to get to know a small selection of studies extremely well (Rutter et al. 2010); a similar process to the analysis of qualitative interviews. I fully concur with Fisher et al. (2006 p.15) that the process makes ‘the reviewer pray



for adherence to the scientific convention of including a section clearly labelled 'methodology'. Many of the studies provided very little methodological detail, particularly on the process of analysis.

The 20 articles consisted of 8 qualitative studies; 2 quantitative studies; and 10 that included both qualitative and quantitative components. Research methods used included questionnaires, interviews, focus groups and ethnography. Most of the studies were carried out in the UK with one study each from Israel and the USA. The 20 articles are listed by publication date in the table below.

**Table Two: The studies included in the qualitative synthesis**

1	Rabin, C. and Zelner, D. (1992). The role of assertiveness in clarifying roles and strengthening job satisfaction of social workers in multidisciplinary mental health settings. <i>British Journal of Social Work</i> , 22, 17-32.
2	Onyett, S., Pillinger, T. and Muijen, M. (1995). Making community mental health teams work. London: The Sainsbury Centre for Mental Health.
3	Carpenter, M. and Platt, S. (1997). Professional identity for clinical social workers: Impact of changes in health care delivery systems. <i>Clinical Social Work Journal</i> , 25(3), 337-350.
4	Duggan, M. (1997). Pulling together: The future roles and training of mental health staff. London: The Sainsbury Centre for Mental Health.
5	Mauthner, N., Naji, S. and Mollison, J. (1998). Survey of community mental health teams. <i>The Psychiatrist</i> , 22, 733-739.
6	Peck, E., & Norman, I. (1999). Working together in adult community mental health services: Exploring inter-professional role relations. <i>Journal of Mental Health</i> , 8(3), 231-242.
7	Peck, E., Towell, D. and Gullivar, P. (2001). The meaning of 'culture' in health and social care: A case study of the combined Trust in Somerset. <i>Journal of Interprofessional Care</i> , 15(4), 319-327.
8	Gullivar, P., Peck, E. and Towell, D. (2002). Balancing professional and team boundaries in mental health services: Pursuing the holy grail in Somerset. <i>Journal of Interprofessional Care</i> , 16(4), 359-370.

9	Colombo, A., Bendelow, G., Fulford, B. and Williams, S. (2003). Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multi-disciplinary teams. <i>Social Science and Medicine</i> , 56, 1557-1570.
10	Carpenter, J., Schneider, J., Brandon, T. and Wooff, D. (2003). Working in multidisciplinary community mental health teams: The impact on social workers and health professionals of integrated mental health care. <i>British Journal of Social Work</i> , 33, 1081-1103.
11	Blinkhorn, M. (2004). <i>Social Worker: Leading roles in mental health</i> . Durham: Northern Centre for Mental Health.
12	McCrae, N., Murray, J., Huxley, P. and Evans, S. (2004). Prospects for mental health social work: A qualitative study of attitudes of service managers and academic staff. <i>Journal of Mental Health</i> , 13(3), 305-317.
13	Larkin, C. and Callaghan, P. (2005). Professionals' perceptions of interprofessional working in community mental health teams. <i>Journal of Interprofessional Care</i> , 19(4), 338-346.
14	Huxley, P., Evans, S., Gately, C., Webber, M., Mears, A., Pajak, S. and Katona, C. (2005). Stress and pressures in mental health social work: The worker speaks. <i>British Journal of Social Work</i> , 35, 1063-1079.
15	Evans, S., Huxley, P., Webber, M., Katona, C., Gately, C., Mears, A. and Kendall, T. (2005). The impact of 'statutory duties' on mental health social workers in the UK. <i>Health and Social Care in the Community</i> , 13(2), 145-154.
16	Evans, S., Huxley, P., Gately, C., Webber, M., Mears, A., Pajak, S. and Katona, C. (2006). Mental health, burnout and job satisfaction among mental health social workers in England and Wales. <i>The British Journal of Psychiatry</i> , 188(1), 75-80.
17	Hurley, J. and Linsley, P. (2006). Proposed changes to the Mental Health Act of England and Wales: Research indicating future educational and training needs for mental health nurses. <i>Journal of Psychiatric and Mental Health Nursing</i> , 13, 48-54.
18	Jackson, C. and Hewitt-Moran, T. (2009). <i>New roles early implementer site project: A report for the NIMHE National Workforce and National Legislation Programmes: National Mental Health Development Unit National Workforce Programme New Ways of Working in Mental Health</i> .
19	Gregor, C. (2010). Unconscious aspects of statutory mental health social work: Emotional labour and the Approved Mental Health Professional. <i>Journal of</i>

	Social Work Practice 24(4), 429-443.
20	Hannigan, B. and Allen, D. (2011). Giving a fig about roles: Policy, context and work in community mental health care. Journal of Psychiatric and Mental Health Nursing, 18, 1-8.

## 2.5 Assessment of quality and relevance

Each of the 20 articles was assessed in terms of their overall quality and in terms of their relevance to the actual focus of my empirical research. In terms of quality Rutter et al. (2010) argued that greater weight should be given to research that appropriately supports their interpretations with quotations from participants: ‘using direct verbatim quotations in the review process sensitises the reviewer to the theme or category and can then be replayed into the report of the synthesis to lend greater authenticity’ (Rutter et al. 2010 p.49). Each article was labelled ‘strong’, ‘medium’ or ‘fairly weak’ in relation to both quality and relevance. For purposes of transparency, these judgments and the reasons given for them are detailed in the table below.

**Table Three: Articles rated by approach, quality and relevance**

Author(s) and Approach	Quality	Relevance
Rabin and Zelner (1992) Quantitative	Medium: Use of self-reports is problematic. Strong use of quantitative analysis. Use of ratings in questionnaires means there are no direct quotations from social workers	Fairly weak: No qualitative data but does highlight the importance of the articulation of the distinctive social work contribution to mental health teams
Onyett et al. (1994) Qualitative & Quantitative	Medium: Some direct quotations in the report but difficult to see the link between conclusions and evidence.	Medium: The views of social workers on being part of a multi-disciplinary team are explored.

Author(s) and Approach	Quality	Relevance
Carpenter and Platt (1997) Qualitative & Quantitative	Strong: Use of direct quotations from social workers as evidence for the themes developed; use of case examples as illustrations	Strong: Explores the identity of social workers in a mental health setting and how this is related to social work values
Duggan (1997) Qualitative & Quantitative	Medium: Comprehensive and clear report. However, there is little discussion of methodology; no direct quotations from participants to give support to the conclusions made.	Strong: Although there are no quotations from social workers, the issues with which the report is concerned are highly relevant
Mauthner et al. (1998) Qualitative & Quantitative	Medium: The findings section does provide a good overview of the current service. However, there is no information given on the qualitative analysis and no direct quotations from participants.	Fairly weak: Many areas were not relevant. Themes from the interview are relevant but the professional background of participants is not identified
Peck and Norman (1999) Qualitative	Medium: Very little discussion of methodological issues or quality criteria but the process of review, amendment and validation with each group is a type of membership validation.	Strong: The social workers' construct their own 'story' in their own words (similar to a narrative approach); examines social work culture, identity and inter-professional working
Peck et al. (2001) Qualitative & Quantitative	Strong: Very detailed methodological information; statements are backed up with direct quotations; limitations are acknowledged	Strong: Explores identity; social workers being transferred to a Health Trust; boundary work; culture being enacted in talk and text
Gullivar et al. (2002) Qualitative	Strong: Very detailed methodological information; statements are backed up with direct quotations	Strong: Explores professional boundaries in mental health teams
Colombo et al. (2003) Qualitative & Quantitative	Medium: Ethical issues of power in selection of participants are discussed; claims made are supported by direct quotations; results are clearly shown in tables. However, there is no mention of the successful examples of inter-agency co-operation	Medium: The implicit models of mental disorder are a way of explaining some of the conflict between members of CMHTs.
Carpenter et al. (2003) Qualitative & Quantitative	Medium: Detailed methodological discussion, use of tables and direct quotations. However, some sample sizes were too small	Medium: The study suggests that social workers experience multi-disciplinary working as more negative.
Blinkhorn (2004) Qualitative	Medium: Skilful use of policy and legislation to inform the findings. However, there are no indicators of the numbers of ASWs who identified the various themes; and no direct quotations	Strong: Examines social work values and identity, the distinctiveness of the social work contribution to multi-disciplinary working in mental health services.

Author(s) and Approach	Quality	Relevance
McCrae et al. (2004) Qualitative	Strong: Detailed methodological information; statements are backed up by direct quotations	Strong: Focuses on integration; develops a useful typology
Larkin and Callaghan (2005) Quantitative	Medium: Clear methodology. However, the statistics do not give a full picture of the teams; use of convenience sample	Medium: Examines the perceptions of professionals including social workers in CMHTs. However, results presented only in a statistical format.
Huxley et al. (2005) Qualitative	Medium: Clear methodology and claims are illustrated by direct quotations. However, it does feel like the qualitative part of the study was an 'add on' to the main quantitative research	Medium: The direct quotations from mental health social workers are very relevant. However, it does not seem like a fully qualitative study
Evans et al. (2005) Qualitative & Quantitative	Strong: Detailed methodological information and clear results. However, there are no direct quotations to illustrate the findings.	Medium: Examines the experiences of mental health social workers. However, no qualitative findings are discussed in the article.
Evans et al. (2006) Qualitative & Quantitative	Strong: As above	Medium: As above
Hurley and Linsley (2006) Qualitative	Strong: Discussion of validity and reliability in a qualitative framework; detailed description of the process of analysis; limitations are acknowledged; use of direct quotations	Strong: Qualitative study using interviews with ASWs using an approach similar to narrative research. Focuses on the emotional nature of ASW work.
Jackson and Hewitt-Moran (2009) Qualitative & Quantitative	Medium: Good quantitative information and contains direct quotations. However, there is a complete lack of detail given on the qualitative study	Medium: Provides some relevant quantitative information and contains the views of social workers on non-social workers becoming AMHPs.
Gregor (2010) Qualitative	Medium: Detailed methodological information (including the interview schedule) and direct quotations from service users. However, Gregor only interviewed people that she knew	Strong: The study interviews ASWs about the experiences of working in mental health services.
Hannigan and Allen (2011) Qualitative	Strong: In-depth of information, including the methodological process. Statements were illustrated with lengthy and verbatim quotations.	Strong: Ethnographic approach which focuses on the views of social workers in mental health teams.

## **2.6 The qualitative synthesis: themes found**

### **2.6.1 Overview**

A total of ten themes were identified from the qualitative narrative synthesis: these are presented below. Each theme or statement is linked by the citation of references to all the studies from which it derived. Therefore, each reference is based on primary research data that evidences the point being made (Fisher et al. 2010 p.34). It is imperative to recognise that, rather than being completely discrete and distinct; each individual theme has some overlap with at least one of the other themes. For example, there is a strong connection between social work identity and social work values, and these two themes also link with social work education and training. However, for purposes of clarity and coherence, each theme has been considered separately. In addition, it is important to note is that researchers may use taken-for-granted terms such as 'social work identity', 'social work values', and 'social work culture' without defining what it is they mean by these terms and without acknowledging that such terms may be both value-laden and contested. This means that when combining research findings into themes around such terms it is important to acknowledge that researchers from different studies may not have used the terms in exactly the same ways or hold the same definition of any of these terms.

### **2.6.2 Social work identity**

Social work identity was a major theme of fourteen studies <sup>[1,2,3,4,5,6,7,8,10,11, 12,18,19,20]</sup>. These studies show that social work identity has many components and appears to arise from the knowledge, philosophical approach and values engendered in social work education. Peck and Norman (1999) <sup>[6]</sup> found that the unique contribution of social work is the approach that social workers take to their work, an approach grounded in values, knowledge, and theory. They concluded that values and professional culture were central to social work identity.

Most of the studies found that social workers in mental health teams retained a strong social work professional identity<sup>[3,4,6,7,8,11,18,20]</sup>. For example, Gullivar et al. (2002)<sup>[8]</sup> evaluated the first English combined health and social care trust over a period of 30 months. The majority of social services mental health staff transferred their employment to the trust. Gullivar et al. found that social workers were able to maintain a strong sense of identification with their social care background. They achieved this through distinguishing themselves from health colleagues by articulating principles of social work practice. The Approved Social Workers (ASWs) interviewed by Blinkhorn (2004)<sup>[11]</sup> were also able to identify the different emphasis and approach that social workers brought to mental health teams. This was articulated as a 'social systems' and 'whole person' approach.

The study by Carpenter and Platt (1997)<sup>[3]</sup> examined social work identity. They conceptualised professional identity as having many components, one of which is identification with traditional social work values. For Carpenter and Platt the 'hallmark' that distinguishes social work from other professions is the concern with social justice and oppression. In their study of social workers in the United States, Carpenter and Platt (1997 p.337) found that the social workers struggled to reconcile their sense of professional identity as a social worker with that of a being a 'provider' in the care management system. Carpenter and Platt concluded that social workers who worked in private practice, where the impact of changes in health care delivery were not as profound, were able to maintain an enhanced sense of their social work identity. Carpenter and Platt conceptualised professional identity as the subjectively perceived sense of fit between professional and personal values. This sense that social work identity comes from a correspondence between professional and personal values was also identified by Gregor (2010)<sup>[18]</sup>. Gregor found that the Approved Social Workers that she interviewed appeared to 'embrace and personalise the role, rather than attempt to separate it off as a part that they were required to act by their employer' (Gregor 2010 p.435). In contrast, two of the studies<sup>[2,10]</sup> found that, of all the professionals in the mental health team, social workers tended to identify less strongly with their profession.

The study by McCrae et al. (2004) <sup>[12]</sup> explored the prospects for mental health social work as a distinct discipline in a predominantly NHS structure through interviews with senior mental health service managers and social work academics. The interviews were held during the time when social work was transferring from Local Authority management to mental health trusts. A typology of attitudes emerged from service managers with three broad categories - traditionalists, eclecticists and genericists - a third of respondents identifying with each. Traditionalists supported a unified social work discipline which would remain distinct from the NHS professions; Eclecticists were enthusiastic about multi-disciplinary teamwork and reducing boundaries between roles, but were keen to preserve professional diversity; and Genericists wanted to reduce diversity, remove statutory difference and work towards a generic mental health practitioner.

### **2.6.3 Social work values and the social model**

Social work values were a theme in almost half of the studies. <sup>[3,6,7,9,11,12,14,18,19]</sup> Social work values were seen to be the foundation of social work <sup>[3,6,9,11,12,14,18]</sup> and a component of professional identity. These values were broadly identified as a concern with social justice and the well-being of clients who are oppressed <sup>[3,6,11]</sup>; self-determination <sup>[6]</sup>; empowerment and enablement <sup>[6,11]</sup>; and a holistic approach <sup>[11]</sup>. These values form a social model of mental health. <sup>[11,12]</sup>

Carpenter and Platt (1997) <sup>[3]</sup> asked social workers to rank a list of 10 social work values to indicate which were most important at the time of graduation and which were most important in their current work. They found that there had been a decline in levels of idealism and liberalism over time; a change in focus from a more generalised to a more specific and immediate perspective; a decline in relevance of altruism and a new focus on empowerment and self-determination. Carpenter and Platt concluded that social work values are 'still alive and well' (p.345). The Approved Social Workers interviewed by Blinkhorn (2004) <sup>[11]</sup> felt that 'approved' social work had a further challenging emphasis towards anti-oppressive as well as



anti-discriminatory practice. Social workers were seen to bring a unique values base to the Approved Mental Health Professional role. <sup>[11,18,19]</sup> However, less than one-third of the Approved Social Workers interviewed by Gregor (2010) <sup>[19]</sup> mentioned bringing a different perspective or the social model to the assessment in response to the question on what they considered to be the most important aspects of the job.

Social work values were perceived to be under threat. The dominance of health culture in which social workers are based is one source of threat. <sup>[9,12]</sup> Professional isolation within Community Mental Health teams has led to subordination of the social care perspective <sup>[11]</sup> as the medical model is clearly favoured by psychiatrists and Community Psychiatric Nurses. <sup>[9]</sup> and social workers may find it difficult to keep a hold of social work values in a strong health culture <sup>[7]</sup>. The introduction of the Approved Mental Health Professional role was seen as further weakening the social care perspective <sup>[11]</sup>, particularly as this perspective was seen to be lacking in nursing staff. <sup>[18]</sup> Strong management and supervision was identified as crucial in maintaining the unique values base that social workers bring to the Approved Mental Health Professional role. <sup>[6,18]</sup> However, social workers do not feel supported by their managers. <sup>[5,7,11,14,15,16,19]</sup> These threats to the value-base of social work are likely to have an impact on the future of social workers in Community Mental Health teams as Huxley et al. (2005) <sup>[14]</sup> found that it appears to be a commitment to the values of the social work which keeps social workers in the profession.

#### **2.6.4 Social work culture**

Social work culture was a theme in five of the articles. <sup>[6,7,8,9,12]</sup> The social workers in the study by Peck and Norman (1999) <sup>[6]</sup> identified a distinct social work 'culture' into which social workers are socialised during their training and which is sustained via social work management and supervision. They described this culture as characterised by: a broad social science theoretical base; an emphasis on self-awareness, personal and emotional growth; and a commitment to social work values. Peck and Norman concluded that values and culture, not tasks, were central

to the identity of social workers. In their study of the first combined health and social care trust in Somerset, Peck et al. (2001) <sup>[7]</sup> also found the continued importance of professions as creators and carriers of 'culture'. Staff identified two distinct cultures – health and social care - operating within the team and enacted in the talk and text of individual team members. Peck et al. concluded that the creation of a combined team is not enough to create cultural change as the distinct cultures of health and social care extended beyond the boundaries of the trust. In their follow-up study in Somerset, Gullivar et al. (2002) <sup>[8]</sup> found that adherence to professional cultures and boundaries was still in place.

Social work culture is threatened when social workers are based within Community Mental Health teams. <sup>[6,7,8,9,12]</sup> Peck and Norman (1999) <sup>[6]</sup> found that social workers were outnumbered by their health colleagues, who did not respect the culture of social work and described social work as being 'under siege' (p.237). Colombo et al. (2003) <sup>[9]</sup> also found clear underlying ideological differences between social workers and their health colleagues which led to conflict and even instances of blackmail. McCrae et al. (2004) <sup>[12]</sup> concluded that social work was yet to be considered as an appropriate investment by integrated trusts resulting in a health dominated culture.

### **2.6.5 The impact of policy and legislation**

Several articles <sup>[2,3,4,9,11,12,18]</sup> discussed the influence of changes in policy and legislation on social work practice. These changes generally were seen to have had a negative effect on social work. For example, Onyett et al. (1994) <sup>[2]</sup> argued that the introduction of care management created considerable confusion among social workers with respect to their own roles as purchasers or providers, and the roles of colleagues in the team. Similarly in the US, Carpenter and Platt (1997) <sup>[3]</sup> found that the introduction of managed care meant that social workers felt a sense of disconnection between their social work value base and the role they were having to perform in the workplace. This had an effect on their sense of social work identity. Duggan (1997) <sup>[4]</sup> described how the demands of purchasers of services and training

consortia are forcing a reconsideration of the skill mix required in mental health services. This imposes new pressures on the existing mental health workforce.

The vast majority of the social workers interviewed by Blinkhorn (2004) <sup>[11]</sup> felt that most of the changes over recent years introduced by the Labour government's modernisation programme, had made a positive difference to service users. However, they felt that moving social work to Care Trusts without proper consideration had been professionally isolating and damaging to the evolving integrated structure. The social work interviewees argued that this had led to further subordination of the social care perspective. The introduction of the Approved Mental Health Professional was seen to be likely to lead to a further watering down of a social care perspective in assessment for compulsion.

### **2.6.6 Emotional impact**

The emotional impact of working as a social worker in a mental health team was highlighted by nine of the studies <sup>[2,5,7,10,11,15,16,17,19]</sup>. The earliest of these studies was 1994 and the last 2010 so it seems that emotional impact has been a constant and enduring theme over the years. Overall, social workers in these studies were burnt out, highly exhausted emotionally and experiencing high levels of stress. Two of the studies <sup>[2,10]</sup> found that social workers were generally more stressed than other disciplines in the mental health team. Using the General Health Questionnaire, Evans et al. (2006) <sup>[16]</sup> found that almost half of social workers in the study had a potential psychological disorder; and over half had a probable common mental disorder in terms of their GHQ scores. Approved Social Workers (ASWs) were much more likely to have a potential psychological disorder and common mental disorder when compared to their social workers colleagues in the mental health team who were not yet qualified as an ASW. <sup>[15]</sup> Using a diary method, Evans et al. (2005) <sup>[15]</sup> found that the working patterns of ASWs and non-ASWs did not differ. This suggests that ASWs do very similar work to non-ASWs while also carrying the additional burdens associated with ASW responsibilities and the time spent on ASW duty (an

average of 25 hours a week). Thus, there is an impact on the mental health of all the social workers in mental health teams but this effect is more profound on those working as Approved Social Workers.

In a qualitative study, Gregor (2010)<sup>[19]</sup> interviewed Approved Social Workers to try and understand the complexities of their existing statutory role and how they related emotionally to the tasks of mental health social work. Gregor (2010) argued that a significant amount of emotional labour is required in order to carry out the role of an ASW. She concluded that ASWs unconsciously process a wealth of powerful emotions and feelings. While half of the respondents cited stress and the emotional impact of the work as being the most difficult aspect of the work, only two respondents explicitly identified emotional processes as being one of the most important. Gregor (2010) suggested that the ASWs were largely unaware of the emotional labour that they were undertaking. A key factor for the majority of respondents in this study was the immense support that they received from their ASW colleagues in order to carry on with the role.

The introduction of the AMHP role has led to some disquiet from health professionals in the mental health team. Hurley and Linsley (2006)<sup>[17]</sup>, researchers from a nursing background, discussed the concern expressed by nurses that being involved in statutory detention of service users on their caseload would irreparably damage the therapeutic relationship the nurse has formed with that person. To examine this claim, Hurley and Linsley<sup>[17]</sup> used a questionnaire and interviews to explore the experiences and perceptions of ASWs regarding the impact of invoking statutory powers under the Mental Health Act on the therapeutic relationship. Findings from the interview data confirmed that the therapeutic relationship is affected: it was strengthened; required rebuilding; or was irrevocably damaged. Hurley and Linsley<sup>[17]</sup> found that a very powerful emotional theme arose from the data: key words expressed by all the social workers in the context of considering restrictive care were 'hostility' and 'emotional challenge'. All the ASWs in the study expressed an emotional component across a broad spectrum of emotions: from

'horror', loneliness, to the 'buzz of the job'. Thus, the study by Hurley and Linsley<sup>[17]</sup> confirmed the emotional impact of mental health social work on both the social worker and the service user.

Perhaps not surprisingly, the emotional impact of the job coupled with a perceived lack of support from management<sup>[5,7,15,16,17,19]</sup> leads to social workers experiencing low satisfaction with their jobs. The study by Carpenter et al. (2003)<sup>[10]</sup> demonstrated an association between stress and job satisfaction and that role clarity was a predictor of job satisfaction. Many of the studies<sup>[2,4,5,8,10,13,19,20]</sup> found that social workers did not seem to be clear about their roles within the mental health team. The next section will explore the theme of the social work role.

### **2.6.7 The social work role**

The theme of social work role was found in sixteen articles<sup>[1,2,3,4,5,6,7,8,9,10,11,12,13,18,19,20]</sup>. Articles variously examined role clarity; changing roles; role confusion; overlap between roles / role blurring; and role conflict. Professionals in CMHTs were found to be confused about their own roles<sup>[4,2,5,]</sup> and the roles of other members of the team<sup>[5,13,19]</sup>. For example, in her comprehensive review of the roles and training of mental health staff working in CMHTs, Duggan (1997 p.56)<sup>[4]</sup> found that 'the dominating influence on the current training agenda continues to be the need of each professional group to define autonomously its own role and boundary'. There is some evidence that social workers struggle to define their role more than other professionals in the CMHT.<sup>[2,6]</sup> Onyett et al. (1994)<sup>[2]</sup> found that despite being second only to nurses in the amount of time dedicated per week to their CMHT, social workers tended to be comparatively unclear about the role of the team and their role within it. Onyett et al. argued that this is due to lack of clarity of the distinctiveness of the social work. Identifying the distinctive contribution of the social work role in mental health teams appears to be a key issue.

Role clarity appears to be associated with job satisfaction. The study by Carpenter et al. (2003) <sup>[10]</sup> demonstrated that role clarity was a predictor of job satisfaction. This might explain the findings above that social workers are less satisfied with their jobs than other professionals in the CMHT: they are the group most unclear about their role. Role clarity was also linked to changing roles, role overlap, and role blurring. <sup>[4,5,6,8,12,18,20]</sup> Duggan (1997) <sup>[4]</sup> pointed out that overlapping functions, skills and knowledge is an inevitable consequence of multi-disciplinary working. Members of CMHTs were concerned that the move towards greater multi-disciplinary working would lead to a loss of distinctive roles and de-skilling. For example, Duggan (1997) <sup>[4]</sup> found high levels of professional disquiet about changing roles, a lack of confidence in identifying what each profession distinctively contributed, and a fear of de-skilling. However, role blurring is not inevitable. Hannigan and Allen (2011) <sup>[20]</sup> carried out an ethnographic study into the roles and responsibilities in CMHTs across two contrasting sites in Wales. In one area, professional roles remained traditionally defined. However, in the other area, there had been a move towards generalist roles over time with a high degree of occupational boundary blurring between nurses and social workers. Hannigan and Allen <sup>[20]</sup> explained the differences between the areas as due to local organisational features. A context of limited resources and inability to recruit a wide range of professional occupations led to a blurring of roles in the second area. However, knowledge and professional identity were still important for ensuring enlarged roles such as care coordination. Hannigan and Allen (2011) concluded that members of professional groups can expend considerable energy by engaging in (re) negotiations over roles and responsibilities.

Evaluating the first English combined Health and Social Care Trust, Peck et al. (2001) <sup>[7]</sup> and Gullivar et al. (2002) <sup>[8]</sup> also found (re) negotiation of boundaries between professional groups. One year after the integration, Peck et al. (2001 p.326) concluded that far from creating a shared (or blurred) culture, staff were 'patrolling the perceived boundaries of their profession with added vigilance'. However, two years after the integration, Gullivar et al. (2002) <sup>[8]</sup> found that there had been a blurring of roles between nurses and social workers: they had taken on new roles

even though they had not received sufficient training to do so. Despite this role blurring, Gullivar et al. <sup>[8]</sup> found there was ongoing strong professional attachment and a reported need to retain distinct roles at times. The article concluded that boundaries and boundary activity are inevitable in multi-disciplinary teams.

In terms of role clarity and role overlap, two of the studies <sup>[4,11]</sup> point to a way forward. They show how it is possible to identify core and overlapping skills and roles shared by all members of CMHTs while still maintaining distinctive and specialist roles and skills unique to any one profession. Duggan (1997) <sup>[4]</sup> identified the core skills and roles required by all staff working in CMHTs. However, none of the articles defined the distinctive and specialist roles and skills that social work contributes to mental health teams.

The (re) negotiation of boundaries between professional groups may lead to role conflict. <sup>[1,4,5,7,8,9,10,18,20]</sup> Rabin and Zelner (1992 p.18) <sup>[1]</sup> claimed that 'it is in the mental health setting that the stresses and challenges of multidisciplinary integration are optimal'. For example, in the team in the study by Hannigan and Allen (2011) <sup>[20]</sup> where professional roles remained traditionally defined, there was a history of tension between professions. Indeed, there appears to be more conflict for the social workers in these teams. Carpenter et al. (2003) <sup>[10]</sup> found that social workers experienced higher role conflict and more stress than other professions. Colombo et al. (2003) <sup>[9]</sup> and Rabin and Zelner (1992) <sup>[1]</sup> explained this in terms of the underlying ideological differences between health and social services. This means that communication is often defined in terms of a struggle where each attempts to control the other. For example, a social worker in the article by Colombo et al. described how social workers occasionally attempted to use their power in Mental Health Act Assessments to control the influence of the medical model. Jackson and Hewitt-Moran (2009) <sup>[18]</sup> identified some potential sources of conflict arising from the introduction of the AMHP role. Due to pay differentials, social workers would be acting as practice assessors for health colleagues who may be earning more than they are for undertaking the same role.

## **2.6.8 Education and training**

Three studies <sup>[4,7,9]</sup> refer to an explicit link between social work identity and culture as an enactment of professional education and socialisation. Colombo et al. (2003) <sup>[9]</sup> explored the influence of implicit models of mental disorder on shared decision-making within community mental health teams. A framework was developed identifying six explicit models of mental disorder to identify the range of model patterns implicitly supported across each of the study's multi-agency groups. Colombo et al. <sup>[9]</sup> found clear differences between practitioner groups. Psychiatrists (91.3%) and CPNs (60.8%) clearly favoured the medical approach. Almost half (47.5%) of the social workers preferred the social model with a further 36.7% preferring the psycho-therapeutic model. Colombo et al. <sup>[9]</sup> concluded that the findings demonstrate that each group implicitly supports a complex range of model elements that appear to be explicitly linked to their education and training.

The study by Duggan (1997) <sup>[4]</sup> aimed to review the roles and training of mental health staff in order to identify the core knowledge, skills and attitudes they require across specialisms. The review formed the basis of a proposed training framework. Duggan <sup>[4]</sup> argued that pre-qualification training lead to differences in the outlook and philosophy of different professions and that this mitigates against interprofessional working. She maintained that mental health services are struggling to establish interprofessional working as the majority of the existing workforce was trained to work in more traditional and uni-professional settings. Duggan (1997 p.68) concluded that 'there 'must be a willingness to establish and implement new approaches to staff training and education – even if this involves some loss of autonomy on the part of the professions'.

## **2.6.9 Management and supervision**

Many mental health social workers do not feel supported by their managers. <sup>[5,7,11,14,15, 16,19]</sup> For example, 43% of the social workers in the study by Evans et al.



(2006)<sup>[16]</sup> felt undervalued at work. 22% were 'mostly satisfied' with their current employer; 37% were ambivalent; 41% were dissatisfied. Many of the ASWs in the study by Gregor (2010)<sup>[19]</sup> did not feel valued by their management, feeling that support only came from other ASWs. Only five of the 25 interviewees received individual supervision for their ASW work. Gregor found that the high levels of stress and anxiety experienced by the ASWs were not being sufficiently acknowledged by managers. The social workers in the study by Blinkhorn (2004)<sup>[11]</sup> felt professional isolated since they had been 'hived off' to the Trust without an effective link back into Social Services. Maintaining this link was identified as important by Jackson and Hewitt-Moran (2009)<sup>[18]</sup> in order that social workers maintain their unique value base. A decade earlier, Peck and Norman (1999) had identified that strong professional support and supervision were crucial to ensuring a distinct social work contribution to mental health services.

Duggan (1997)<sup>[4]</sup> explored the difficulties by the new managerial structures that are necessary in CMHTs. She found that the traditional professional support structure had become blurred in terms of managerial command, accountability, and supervision. Huxley et al. (2005)<sup>[14]</sup> observed that there was poor integration of social services and NHS trust at management level and a lack of support. Joint working practices are important. For example, Larkin and Callaghan (2005)<sup>[13]</sup> found a strong significant relationship between teams with a joint risk policy and a joint supervision policy and a positive perception by professionals of interprofessional working.

#### **2.6.10 Relationship between social workers and service users**

Only four of the articles<sup>[2,4,17,19]</sup> explicitly discussed the relationship between social workers and service users. This small number may be due to the search terms used which result in a focus on professionals. However, the lack of a consideration in the majority of the articles of the impact of interprofessional working in mental health services on the lives of services users can be seen as a serious omission.

One of the objectives of the study into the future roles and training of mental health staff by Duggan (1997)<sup>[4]</sup> was to identify the needs of service users and establish the range of required skills to meet those needs. The study included a survey of service users' needs of professionals which found that frequent changes of key staff, inadequate communication with users, and offensive and patronising attitudes amongst staff were cited by the service users. Duggan (1997) concluded that service users would like to see professionals develop a more holistic understanding and empathy with their distress.

Gregor (2010)<sup>[19]</sup> contended that ASWs unconsciously process a wealth of powerful emotions and feelings for service users with many of the ASW respondents feeling that their role was misunderstood by service users and their families. In their small scale study Hurley and Linsley (2006)<sup>[17]</sup> found that, of the twenty-two ASWs who responded to their questionnaire, nineteen had undertaken Mental Health Act assessments with service users who were active on their case lists. Ten of these ASWs stated that this had had an impact on their relationship with the service user with three describing it as irrevocably damaged.

On a more positive note Onyett et al. (1995)<sup>[2]</sup> concluded that although staff were feeling significantly emotionally over-extended and exhausted, overall they did not appear to be experiencing detachment from service users which can be a symptom of emotional burnout. The study also found that feeling able to work effectively with service users was a major source of feeling a sense of reward at work.

### **2.6.11 Bureaucracy**

Only two studies<sup>[2,14]</sup> mentioned bureaucracy as an issue. The social workers in the study by Huxley et al. (2005)<sup>[14]</sup> worked an average of 43 hours a week and the qualitative diary data illustrated that the main reason for this was to complete paperwork. Thirty-one per cent of the workers in the CMHTs surveyed by Onyett et al. (2005)<sup>[2]</sup> cited bureaucracy as a source of pressure. The lack of emphasis on

bureaucracy in the studies is remarkable as it is a major theme in writing on social work more generally, particularly in adult social work and child protection. For example, in their two year ethnographic study of the impact of the Integrated Children's ICT system (ICS), White et al. (2010) found that social workers reported spending 60-80% of their available time at the computer. The recent Munro report (2011) highlighted that the current system in child protection is over-bureaucratized, overly prescriptive and focused on procedural compliance.

## **2.7 A critique of systematic reviews**

Martyn Hammersley (2001), writing about educational research, has argued that systematic reviews apply the positivist model to the production of literature reviews and portray research findings as necessarily superior to other sources of evidence. He pointed out that there is a striking similarity between the emphasis on transparency in systematic reviews and the demands for accountability and transparency in an audit society. Hammersley (2001 p. 548) warned that this approach 'assumes that there is just one possible relationship among different studies: an additive one'. Namely, there is an assumption that all of the studies that are included in any particular review have investigated the same issue, in a similar way, so that their findings can be satisfactorily combined. Of course, this is true of the present review. As I highlighted earlier, it is important to acknowledge that researchers from different studies may not have used terms such as 'social work identity' in exactly the same ways or hold the same definition of any of these terms.

## **2.8 The value of the systematic review**

For my purposes – to discover the scope of previous empirical research in the area of social work identity and mental health teams – a systematic review does have something to offer. When a review is carried out at the beginning of the research project, as it was here, it allows the researcher to develop an awareness of the approaches that have been taken by other researchers to the topic of interest. It

also gives the researcher some understanding and knowledge of the findings and key themes relating to the topic of interest. Thus, this can be a valuable starting point for any research project.

## **2.9 Conclusion to the literature review**

The qualitative narrative synthesis has allowed for an overview of all the empirical research that has been published on interprofessional interagency mental health teams and social work identity since 1990 up to the point that the search was undertaken between May and July 2011. The key themes from this research have been outlined and provide a sound basis for the present research.

It is interesting to note that none of the studies contained within the literature review have an ethnomethodological focus. Instead, as the research process unfolded, my interests and influences gradually developed, very much led from the interview data. At the time of undertaking the search of the literature, I did not know – and indeed could not have known – that my research focus would develop in the way that it did. To remedy this, a review of the use of ethnomethodology and conversation analysis in social work research is included at the start of Part Two of the findings chapters. Other literature – empirical or otherwise – that has a direct relevance to the research will be included in the other chapters of the thesis on a ‘when-and-as-needed’ basis (Wolcott 2009 p.68-69). In this way, connections can be made between my study and previous research.

## Introduction to the Findings Chapters

The findings chapters are presented in two parts, following the work of Turner (1971); Wieder (1974); and ten Have (2004).

The first part, 'Being a Social Worker', is a more traditional reporting of *what* the social workers talked about in the interviews: the focus is on the interviews *as a resource*. The objective here is to present being a social worker from the participants' point of view.

The analytic focus shifts in the second part of the findings chapters to the interview *as a topic*. In this part, 'Doing Being a Social Worker, ethnomethodological and conversation analysis are employed to understand *how* social work identity was accomplished *within the interview interaction*.

## Part One: Being a Social Worker

Part one of the findings chapters is concerned with a more traditional reporting of *what* the social workers talked about in the interviews. Here the focus is on the interviews *as a resource*. The purpose of this first part of the findings section is to present the themes that emerged from the interview talk. Although ethnomethodological insights will be used, the themes are discussed using a more ethnographic method of analysis. Thus, this is an attempt to provide the reader with an understanding 'from the native's point of view' (Geertz 1983 p.55). Long extracts from the interview data are used to provide the reader with a sense of the unfolding nature of the interaction.

Part one consists of two chapters. The focus of the first chapter is on what the social work interviewees considered as 'real' social work. Throughout the interviews, the social workers were concerned to delineate what was 'real' or 'proper' social work. This 'authentic realm of social work' (Pithouse 1998 p.21) was depicted as involving autonomous work in the community with mental health service users. However, the social workers struggled to define social work. Instead of having a clearly defined role, social work was depicted as intangible; as being without clear margins and boundaries, filling in the gaps left by other professions. Being a real social worker was also a theme of the interviews and social work identity was portrayed as intrinsic to the self with congruence between personal identity and values.

In the second chapter, the attention moves to an analysis of being an Approved Mental Health Professional (AMHP). The AMHP role can be conceived in two senses: the very narrow and specific sense of AMHP duty under the Mental Health Act 1983; and the more general and much wider role of working as a mental health social worker in a Community Mental Health team. The chapter will explore the AMHP role in both the narrow and the wider sense. Issues of AMHP duty as 'dirty' or prestigious work and the implications of being seconded to a Health Trust will be discussed. The

chapter will conclude with a discussion of the future of mental health social work as seen by the AMHPs.

## 3 Real social work

### 3.1 Introduction

The focus of this chapter is on what the social work interviewees considered as 'real' social work. Through their talk the social workers delineated what was 'real or 'proper' social work. This was accomplished in very artful ways. This chapter will explore 'real' social work in more depth. It will begin with an analysis of a key extract from the interview with Eva where she makes a distinction between the 'rubbish' and the 'treasured'. In this extract, Eva demarcates what she considers is 'real' social work and what she regards as not social work. For Eva, bureaucratic demands detract from real social work. This point is picked up in the interview with Paul. A series of extracts from his interview will be examined where he talks about the pervasive nature of bureaucratic demands. The next section explores the contention that social work is intangible: specifically, that mental health social work lacks clear cut margins and boundaries and that social work fills in the gaps left by other professions. The final section of the chapter is concerned with a key theme from the interviews: namely, that social work is intrinsic to the self.

### 3.2 The 'rubbish' and the 'treasured'

In her interview, Eva provided a clear distinction between what is 'real' social work and what is not real social work. Real social work is the 'treasured'; the rest is the 'rubbish'. Earlier in the interview, Eva had already talked about the difference between social work and the other jobs that her friends are doing and I ask her to enlarge on this further.

- 1 Eva: Awww I feel so sorry for them, you know, particularly ones who
- 2 work in finance and they're just working for the man and they hate their
- 3 jobs and it makes them depressed and they have no, no control over
- 4 their lives, really, umm we have such a lot, we have quite a lot of control
- 5 over our day to day, how we manage things, as long as we get on with it



6 we're left to it. And [pause] I suppose I [pause] so some friends have  
7 gone into that, other friends have gone into sort of the art world and  
8 their job's just so difficult because there is no [pause] well there is no  
9 structure there. Another friend has ended up being unemployed because  
10 they can't find their way and friends that have gone into teaching and  
11 they hate it because it's so awful and they're overworked. And then  
12 friends who went into children and families and it's just so awful and  
13 they all hate that

14 Lisa: Really?

15 Eva: Oh they're not agents of social change at all, are they? They don't  
16 do anything hands on so [pause] yeah, yeah [laughs] my friends that are  
17 doing PhDs [laughs]

18 Lisa: [laughs]

19 Eva: They look like they are having a fun time, you know, and they're all,  
20 you know, they're all in their ivory towers, aren't they? But yeah they  
21 have a nice time [long pause] yeah [pause] yeah unhappy a lot of people  
22 are unhappy

23 Lisa: And you don't feel like that?

24 Eva: No, no I don't think that I [pause] well obviously I'd prefer to be a  
25 backing dancer or a film star

26 Lisa: [laughs]

27 Eva: But in reality [laughs] I wouldn't be anything else.

Here Eva contrasts social work with the other jobs where her friends are employed. The friends employed in finance 'are working for the man' and have 'no control over their lives'; in contrast, social workers 'have such a lot, we have quite a lot of control over our day to day, how we manage things, as long as we get on with it we're left to it' (line 4). Although, Eva downgrades the amount of control from such a lot to quite a lot, this idea of social workers having autonomy and independence in their work concurs with Pithouse's (1984) notion of social work as an inherently 'invisible' trade. Drawing on symbolic interactionism and ethnomethodology, Pithouse (1984) contended that social work is invisible in three particular ways: first, the majority of social work practice with service users is unobserved by colleagues or managers;

secondly, the outcomes of social work intervention are uncertain and ambiguous; and thirdly, social work practitioners rely upon rarely stated motives and taken for granted assumptions in order to accomplish their daily work (Pithouse 1998 p.4-5). Eva's description of being 'left to it' (line 6) relates to the first point made by Pithouse: mental health social workers visit service users in their own homes unobserved by others. They control the work they do with service users; and this work is also not 'visible' to others. There are often no visible outcomes from this work; a service user may become unwell despite any intervention but this is not seen as a negative reflection on any work that the social worker has done. Rather, this is seen as simply the nature of the work. It is only if a service user was to commit suicide or seriously harm someone that the work would be scrutinised.

Next, Eva contrasts mental health social work with children and families social work. Here Eva is defining what she sees as 'real' social work: it is being 'hands-on' and being an agent of social change (lines 15-16). This notion that social work is concerned with social change is fundamental to the definition of social work produced by the International Federation of Social Workers (2000).

The social work profession promotes change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being... Principles of human rights and social justice are fundamental to social work (The International Federation of Social Workers 2000)

Eva then implicitly refers to my status as a PhD student using humour to describe this as being in an 'ivory tower': it is therefore not 'hands-on' and it is 'fun' rather than being involved in the serious business of social change (lines 19-20). This idea of a gap between social work academia and social work practice is a major concern in social work writing. For example, the Final Report of the Social Work Taskforce (2009 p.19) concluded that educators 'need to share in the real challenges posed in service delivery and avoid any temptation to criticise from the sidelines'. Finally, after shared laughter, the coda is that Eva 'wouldn't be anything else' (line 27). This

is a very positive view of social work and in sharp contrast to the negative public image of social work. I comment on this and then ask her to elaborate:

- 1 Lisa: That's really positive to hear. Ummm and is that being the agent of  
2 social change that really you like?
- 3 Eva: Yeah, yeah, yeah. I feel that there's just this tiny little niche in  
4 society and I'm in it. And it is the control that I have. I mean I do wonder  
5 how much I'd like my job if you're so dependent on your management  
6 and your team and I wonder. I wonder how, you know, how much of it I  
7 am just left to it. I wonder how I'd respond if I was managed differently.  
8 But I've always been left to it so I don't know. But it's always been in the  
9 back of my mind, you know, what would you be like if you had someone  
10 saying because I know that in some teams managers say "*you must be*  
11 *here at nine, you must stay until five, what are you doing?*", you know,  
12 and I just couldn't bear I'd get really [pause] I think I'm quite rebellious  
13 and I'm in charge of my own destiny and my caseload and that works  
14 quite well with my character, I think ummm [long pause] So it's the social  
15 change and it's a social job in that they're nice to us, ish, you know, I  
16 think.

Again, Eva makes the link between social work and 'social change'. In a poignant description, Eva defines social work as 'there's just this tiny little niche in society and I'm in it' (lines 3-4). She reiterates that it is the control over her own work, being 'just left to it...I've always been left to it', that she values (lines 7-8). Again, social work is portrayed as autonomous, invisible work. Eva uses 'active voicing' to emphasize that she 'just couldn't bear' having a controlling manager (lines 10-11). Robin Wooffitt introduced the term 'active voicing' to replace 'reported speech'. In active voicing, 'speakers are designing certain utterances to be heard *as if* they were said at the time' (Wooffitt 1992 p.161). Here Eva uses active voicing to present the words of 'managers' as a generic category of people, not merely reporting on what an individual manager has actually said to her.

The next phrase is interesting. Here this sense of social workers as autonomous and in control is shown as intimately intertwined with Eva's personal identity and so there is congruence between her social work and personal identity ['that works quite well with my character']. Being 'rebellious' (line 12) links with social workers as

being assertive, a key theme in all of the interviews. Eva concludes her reply by once again affirming this link with social change (line 14-15).

My next question seeks clarification. My vulgar competence means that I am aware that there are demands on the time of social workers which have an impact on invisible work.

1 Lisa: So you manage your own time, then really, and as long as  
2 everything is ok, everyone leaves you alone, is that what you are saying?

3 Eva: Well, hmmm, that's difficult, isn't it, because every week [her  
4 manager] will come out of her office and go "*you haven't done this stats*  
5 *and this stats*" and the Trust will ask all these things of us and I won't do  
6 them and I won't do them and eventually I clear a whole day in my diary  
7 and I'm very angry about that and I don't like doing that umm [pause] so  
8 obviously I'm not completely left to it. I have to do these things. I  
9 suppose - what I say to myself is that there's about a third of my time  
10 that I'm out in the community and the rest of the time I'm made to do  
11 rubbish

12 Lisa: [laughs]

13 Eva: But I've resigned myself to that and I do the rubbish, that's fine, and  
14 that third of that time, nobody cares as long as I've ticked the boxes and  
15 done the CPAs. They never look at what I'm actually doing, they don't  
16 care what I'm actually doing, so I do what I think is best in that time and  
17 that's what's treasured, that's the good thing, you know. Most of the  
18 time I'm doing what I consider to be pointless rubbish.

Eva acknowledges my implicit questioning through her 'Hmmm' and 'isn't it?' (line 3). Eva positions her manager and the Trust as making demands on her time which make her 'very angry' and which she resists. Again, the use of active voicing adds a sense of drama and vividness (lines 4-5). Here her use of 'so obviously' (line 8) can be seen as a direct response to my implicit questioning.

In a key section, Eva contrasts the 'rubbish' and the 'treasured'. The 'treasured' the third of the time that Eva spends being out in the community doing invisible autonomous work with service users (lines 15-17). What is treasured is real social

work. In contrast, the 'rubbish' is the two-thirds of the time that she spends doing bureaucracy; the 'stats' [statistics] and the 'CPAs' [Care Programme Approach forms]. Eva describes dedicating a whole day to this 'dirty work' (Hughes 1948) of doing the 'pointless rubbish' (line 18). I ask Eva to describe the rubbish in more detail. Her reply is very lengthy.

1 Lisa: And can you tell me what those things are? Are they like the  
2 paperwork? Are they

3 Eva: They're like, so we have a computerised records system and mostly,  
4 that's designed because it produces stats and [pause] it's not smart  
5 enough to produce the stats from your entries of what you've actually  
6 done, you have to tell it what you're actually done. You have to give it  
7 dates, you have to give it times, you have to go through your patients  
8 and give them like numbers from a list [sighs] so do they fall into this  
9 group and that group. And I'm kind of constantly ummm [pause]  
10 reducing them, the people, to numbers and ummm that gets produced  
11 as stats and I just think, you know, why? I know that they have to get  
12 funding. I know why they do it, they need to do it and they wouldn't get  
13 any money if they didn't do it and I know they sit there going "*god, this is*  
14 *rubbish*" and I know [her manager] comes out of her office and she says  
15 "*I know this is rubbish, Eva, but you haven't done your HoNOS scores*".  
16 And we all know it's rubbish but it's just the way it works, I suppose.

In her reply, Eva defines the 'rubbish' in terms of the computerised record system, producing HoNOS scores and thus reducing people to numbers (line 10). This refers to the HoNOS PbR [payment by results], a needs assessment tool designed to rate service users' care needs based upon a series of eighteen scales. It is based upon Health of the Nation Outcome Scales, originally developed by the Royal College of Psychiatrists, with the addition of several ratings to capture 'historic' information. The HoNOS PbR is used to assess service users and allocate them to a Mental Health Care Cluster. Eva repeats the word 'rubbish' three times in quick succession – not only do 'we all know it's rubbish', a collective view, but even her manager is depicted as able to see that this is rubbish, using active voicing to emphasise the point (lines 14-16).

In the second half of the same reply, Eva introduces a story about a mandatory training session.

1       Eva: Umm but I think it's [sigh] on the one hand it's just the way it is but I  
2       think on the other hand it is horrible when [pause] we had some training  
3       recently mandatory training on customer care and it was all about trying  
4       to stop the number of complaints that the Trust has by us dealing with  
5       things on a, what they were trying to get us to do was to say sorry to  
6       people and be kind and while we were very understanding of that and  
7       we would like to be kind and we would like to say sorry to people, the  
8       feedback we were giving was you spend most of your time trying to  
9       make us, you operate as a business, and you spend most of your time  
10      telling us to fill out these forms and meet these targets so we then  
11      operate as business people, we operate as a business and so that then  
12      when somebody comes in and they need something extra and they need  
13      that ten minutes of kindness, you haven't got that ten minutes or  
14      particularly when they are upset about something that isn't your fault  
15      you don't want to say sorry because actually you want them to get cross  
16      and complain because otherwise how's anyone going to know about it  
17      umm and you don't want to say sorry to them. It's ummm and you don't  
18      want, but you feel terrible because you would want to sit down and have  
19      that conversation and talk about why they're upset and about what's  
20      happened but actually if you do that there's no way of recording that.  
21      They measure our performances on these bizarre, you know, forms that  
22      mean nothing and that isn't represented and so actually we could  
23      choose to still do that but we're human beings aren't we and we  
24      therefore that person hasn't as much power over us as our managers  
25      and we turn round and be rude and say "*I'm sorry, I haven't got time for  
26      this, I need to sit and do my paperwork*". And that's, that's horrible. It's  
27      even horrible that I'm saying that but that is that's what happens, your  
28      poor disempowered mentally ill person is sitting there and you're going  
29      "*I'm going to do the HoNOS scores*".

Through this story, Eva illustrates the contrast between the 'rubbish', i.e. the bureaucracy, and the 'treasured', i.e. real social work. The Trust is positioned as operating as a business, a phrase that she emphasises by repeating three times (lines 9 and 11). This has a direct impact on service users who are denied 'ten minutes of kindness, you haven't got that ten minutes' (line 13). This fundamental element of real social work, supporting service users in distress, is not even included in the bureaucratised system: 'you would want to sit down and have that

conversation and talk about why they're upset and about what's happened but actually if you do that there's no way of recording that' (line 18-20). The bleak coda of the story uses active voicing to demonstrate the stark dilemma between the business model of the Trust and real social work: 'your poor disempowered mentally ill person is sitting there and you're going "*I'm going to do the HoNOS scores*". Here the 'managers' are positioned as having more power over social work practice than the 'disempowered' service user (line 24). This is a complete reversal of one of the core values of social work, empowering service users, and providing a needs-led service (NHS and Community Care Act 1990). I do not think that Eva would have told this story to a non-social worker as it presents social work in a negative light. My sense that Eva told me this story only because we are both members means that revealing it here makes me feel guilty and anxious in the same way as I described earlier in the methodology chapter; as if have a 'dirty secret' because I am 'betraying' other social workers. However, I think that it is important to discuss the emotional impact that feeling 'torn' between the rubbish and the treasured has on Eva – and, of course, on the service user. The interview continues with my asking about the response to this feedback.

1 Lisa: And what did they say when you were saying that?

2 Eva: It was quite umm [pause] their attitude, her attitude was [pause]  
3 she said she understood, she knew what we meant and she'd feed that  
4 back to the managers. I think that her agenda was [sigh] her agenda was  
5 we have to reduce the number of complaints we get a year. I don't think  
6 she cared how we did it and again that's, you know, [pause] she doesn't  
7 care about the person crying for ten minutes, she only cares that her  
8 stats say we're getting fifty complaints a week, that the staff are rude  
9 [laughs]

10 Lisa: [laughs]

11 Eva: She doesn't care why we're doing it she just doesn't want us to do  
12 it. And that's a massive political thing, isn't it? Is the Trust, does the NHS  
13 deliver care or is it a business and they can't we can't do both. We will  
14 do one or the other or we can do both if they provide lots of extra  
15 people but they won't. And you feel very torn. I could see in this training  
16 that we were all very angry going "*god, another thing that you want us*

- 17        *to do. It's one more thing, one more thing that we've done wrong.*  
18        *Arghhh!*" It's very frustrating.

In this story, the NHS is positioned as having two competing and incommensurate aims: to deliver care or to operate as a business. The trainer epitomises the business model. Her focus is purely on the statistics and not on the emotional impact on the service user ['she doesn't care about the person crying for ten minutes, she only cares that her stats say we're getting fifty complaints a week, that the staff are rude']. Gallows and bleak humour (Pithouse 1998; White 2006) and shared laughter at the expense of the trainer accomplishes our social work identity by distancing ourselves from this 'outsider' (lines 9-10). Eva is 'very torn' between these two aims (line 15). The frustration and anger of the staff about the focus on the NHS as a business is emphasised in the coda to the story by the use of active voicing and the meaningful non-lexical utterance '*Arghhh*' (line 17).

It is notable that active voicing occurred during the codas to the last three stories told by Eva. Holt (2000) showed how direct reported speech is more regularly used at the climax of a story. Holt (2000) argued that:

When people tell stories, they want the recipient to agree with their interpretation or assessment of the incident (e.g., that it was funny or complaint worthy). However, rather than making their assessment of the event explicit, reported speech (within a sequence containing implicit assessment) can be used to give the recipient access to the utterance in question... One could view this as one of the subtle ways in which intersubjectivity is established and maintained. (Holt 2000 p. 451)

In these extracts, the use of active voicing as the coda to the stories enables Eva to display her interpretation of the incidents. I pick up on Eva's use of the phrase 'you feel torn' in my response thus affirming that I have come to the same interpretation of the story (line 1 below).

- 1        Lisa: Yes. But you do feel torn between those two models



2 Eva: Oh absolutely. I mean I try and work I try and have days in the office  
3 and days out. So when I'm doing my days when I'm out in the  
4 community I pootle around to people's houses and I do the social and  
5 then I have my days in the office when I just do my paperwork. Umm it  
6 very rarely happens like that because you know crises come up and. I  
7 think that I suppose what happens is because you will deal with the  
8 crisis, then your paperwork mounts up and then it gets to the point  
9 when you do do your paperwork and then it's the poor patient who rings  
10 up then in crisis when you've left the paperwork so long that you have to  
11 do it and you're like "*I can't do anything, no. See you next week, I can't*  
12 *do it*". Umm yes, so torn, so torn

Here Eva uses another story to illustrate the ways in which she attempts to manage these conflicting demands. It is notable that Eva uses contrasting imagery. When she is in the community, Eva is autonomous and 'free' ['I pootle around to people's houses and I do the social'] but when she is in the office, she is pressured and constrained ['I just do my paperwork']. The time in the community is the 'social', the real, invisible social work with service users; in contrast, the time in the office is to meet the demands of the business. However, this clear boundary between social work and business is difficult to manage in practice because people experience times when their mental distress reaches a crisis point (line 10). Once again the impact on the service user is highlighted in this story. The use of active voicing demonstrates the significance of this situation where a social worker feels that she has no choice but to choose the demands of the business over the core aim of social work, to do 'the social' (line 4). It is interesting to note here that Eva uses the term 'patient' rather than the term 'service user' (line 9). The former can be seen as medical term compared to the latter which is a social work term. Arguably, being based in an NHS Trust with health colleagues where the medical model is dominant has influenced the language used by social workers. Again, active voicing is used in the coda to the story (line 11). Finally, Eva reiterates and repeats how 'torn' she is ['so torn, so torn'] to accentuate the deep significance of the impact of being caught between the two competing models (line 12).

Through her talk Eva can be seen as delineating what she describes as the 'treasured': real social work. This is autonomous, hands-on, invisible 'social' work with service users. For Eva, real social work involves being an agent of social change, being out in the community, being 'hands on', and supporting service users experiencing distress. Eva estimates that she spends a third of her time doing real social work; the rest of the time she is doing the 'rubbish'. The 'rubbish' is the bureaucracy: the statistics required to meet the organisational imperatives contained in a computerised business model.

The negative impact of these competing demands of wanting to work with services users whilst being required to undertake output-driven bureaucracy was also identified by Paul. Paul made a reference to bureaucracy very early in the interview during his reply to my first question about becoming a social worker:

Paul: I felt like there was umm I worked well with people umm little did I know how much bureaucracy I was facing [both laugh] but that's another story.

Like Eva, Paul contrasts 'working with people' with 'bureaucracy'. It is notable in this reply that Paul distinguishes the 'bureaucracy story' from the 'becoming a social worker story'; the two are portrayed as unconnected ['but that's another story']. The shared laughter is another example of gallows or bleak humour. Later in the interview with Paul, I returned to the subject of bureaucracy. Paul replies that this has 'increased over time' and become 'output driven really rather than outcomes'. I ask him to explain what this involves and he replies:

- 1 Paul: umm clustering of people, umm payment by results, umm err
- 2 monthly err demands by senior management, terminology such as
- 3 breaches, you know, a care plan hasn't been completed in time, you're in
- 4 breach, so if you don't meet your target the trust payment by results the
- 5 trust won't get paid and therefore service is so it's a very [pause]
- 6 Lisa: Business?

- 7 Paul: Business like exactly and the appraisal system has become very  
8 corporate, umm objectives, exceeding objectives to you know and we've  
9 argued for two or three years that it's practically impossible to set a  
10 [name] council objective for social care and how firstly how do you  
11 demonstrate well you can demonstrate how you meet that but how can  
12 you demonstrate you're exceeding that to move up the pay scales? So at  
13 present, there's a rant coming along, be warned
- 14 Lisa: [laughs]

Here Paul lists the overwhelming amount of bureaucracy involved in being a mental health social worker. If these forms are not completed then it creates a 'breach' whereby the Trust does not get paid (lines 4-5). Paul also describes the introduction of a corporate appraisal system which involves exceeding objectives (lines 7-8). Paul then announces that 'there's a rant coming along' (line 13). Harvey Sacks discussed the issue of 'story prefaces' in his first lecture in Fall 1968. He showed how a speaker regularly informs a hearer about what a story involves in order that the hearer is able to gauge when the story is over (Sacks 1998 Vol. 2 p.10). So here Paul's preface is informing me that he is going to 'do a rant' and thus I am able to recognise the talk that follows as such. This also connects with Garfinkel and Sacks' (1970 p.171) work on formulations; namely, he is 'saying-in-so-many-words-what-we-are-doing'. Indeed, Paul does continue with a 'rant' which concludes with the coda 'It's endless. It just goes on and on'. I ask Paul to estimate how much time he spends with service users and how much time he spends on bureaucracy as a percentage of his week:

- 1 Paul: Umm I reckon it was probably it was about sixty forty service users  
2 sixty and now I would say it would probably be seventy thirty seventy  
3 admin. I can spend as much time as I want with service users but as long  
4 as I'm prepared to stay late and work it and I've personally told senior  
5 management to say that on occasion when there is a big push because  
6 there's either a breach or payment by results and HQ are demanding  
7 that we get our stats higher that it's one or the other and literally you  
8 have to clear your diary to concentrate or but that doesn't take into  
9 account when someone has a crisis or a relapse or you deal with that  
10 and have to let the paperwork suffer. And sometimes it's really hard to  
11 manage it
- 12 Lisa: It must be terrible

13 Paul: Yes [laughs]

Like Eva, Paul estimates that he now spends about thirty percent of his time with service users and the rest of time on bureaucracy, compared to sixty percent when he first qualified (lines 1-2). Also like Eva, Paul describes a situation where 'it's one or the other', i.e. that he has to choose between spending time with service users or time on the demands of bureaucracy (line 7). This has an emotional impact on Paul ['sometimes it's really hard to manage it'] which I acknowledge ['It must be terrible']. Although Paul laughs here I recognise that it is 'troubles-talk'. Gail Jefferson (1984) found that speakers laugh while troubles-telling to show 'troubles-resistance'; displaying bravery and/or that they are coping. The other member(s) of the conversation show 'troubles-receptiveness' by responding without laughing to show that they take the troubles seriously. Thus, I do not laugh.

To summarise, these extracts from Eva and Paul have demonstrated the very difficult circumstances in which mental health social workers are currently working. They both claim that they are only able to spend a third of their time doing real social work; the rest of the time is spent on bureaucracy. This echoes the findings from the two year ethnographic study of the impact and origin of the Integrated Children's System by White, Wastell, Broadhurst, and Hall. White et al. (2010) found that social workers were spending between 60% and 80% of their available time (time when they were not travelling or in meetings) at the computer. Thus, it seems that social workers are now spending increasing amounts of time meeting the needs of the organisation rather than the needs of service users.

The next section of this chapter will examine the notion of social work as intangible. The social workers depicted social work as having unclear margins and boundaries and that social work fills in the gaps left by other professions.

### 3.3 The intangibility of social work

When asked, the social workers could not readily define social work. They are not alone in this. The Interim Report of the Social Work Taskforce (2009 p.33) concluded that the distinct role of social workers in modern public services is unclear and that even social workers themselves struggle to articulate the central role and purpose of the profession. The social workers in my study were no different. For example, in the interview with Cath she stated:

1 Cath: It's like the role of social work: what is social work? Before I started  
2 I knew it was something valuable but you don't really know you can't  
3 label each thing can you? But it can be anything can't it? It can be  
4 anything from the most [pause] innocuous thing to the most [pause]  
5 [breath] I don't know traumatic or important or legal or whatever  
6 perspective you look at.

Here, as in the Interim Report of the Social Work Task Force, Cath is talking about how difficult it is to define what social work is, even for a social worker. Social work can 'be anything' (line 3). Cath positions me as sharing the same group membership through asking 'can you?' and 'can't it?' (line 3). Next Cath makes a direct link with this inability to define social work and the profile of social work:

1 Cath: It's hard isn't it to say what you've done in a piece of work. I don't  
2 know. I think that's probably why social work struggles with its profile  
3 isn't it but you can't say people can't see well I've saved a life because  
4 you do sometimes but not in the medical sense Umm or I prevent abuse  
5 or safeguarding or all these things you again they're labels but they don't  
6 say what you do, do they?

7 Lisa: No, no. Do you think other social workers understand that  
8 shorthand? You could say, safeguarding, today I did this

9 Cath: I think so yes and I think other social workers would say that it's  
10 really difficult to explain what social work is to someone umm cos you  
11 think you just sit and speak to somebody and on the outside that is what  
12 it might look like but I suppose it is everything else in the background  
13 around the periphery, isn't it?

Once more this endorses Pithouse's description of social work as an invisible trade. The work cannot be seen; in Cath's words, 'you can't say people can't see' (line 3) and 'it is everything else in the background around the periphery' (line 13). Moreover, Cath's word 'periphery' is synonymous with being at the 'margins'. Thus, social work is portrayed as not having clearly defined boundaries but operating at the periphery in ways that are unseen. However, it can be seen by other social workers (line 9).

This notion was also presented by Ed:

1 Ed: We really don't have a role. We really don't have a model. Because  
2 we sort of operate between the very sort of underbelly of stuff and the  
3 legal. There's a really kind of weird kind of area that we operate within  
4 and I often think that there isn't a model for us in our society and that is  
5 why the perception is so difficult.

Like Cath, Ed positions social work as not having a clear 'role'. Ed portrays social work as dealing with the 'underbelly', operating within a 'weird kind of area'. Ed reiterates the notion that social work does not have a 'model' in society (lines 1 and 4) and so is difficult for people to perceive (line 5). Again, this aligns with the notion of social work as an invisible trade (Pithouse 1984). Later in the interview, Ed talked about the positive and negative outcomes of not having a clear role or boundaries:

1 Ed: But then we have a lot of freedom as well because no-one really I  
2 was saying to a friend of mine you know "*I can walk into a police station,*  
3 *show my badge and literally walk into someone's cell*", you know. We  
4 have a lot of freedom to do stuff and that's partially because we are the  
5 people who mop up the stuff that other people don't want to do so with  
6 that comes with a lot of criticism and the high profile cases.

Here Ed argues that social workers have 'a lot of freedom'. This connects with Eva's being 'just left to it'; the notion of real social work as being autonomous and independent. Again, it also connects with Pithouse's (1984) notion of invisible work; the freedom to undertake work unobserved by others. For Ed, this freedom comes partially from being 'the people who mop up the stuff that other people don't want

to do'. Thus social work is again depicted as dealing with the gaps left by other professions. However, there is a negative side to this freedom. The 'stuff' that other people do not want to do is directly related to the 'criticism and high profile cases' such as the deaths of Peter Connelly, Daniel Pelka and Victoria Climbié.

Nell also talked about this notion of social work filling in the gaps left by other professions.

1        Nell: a generic person like me I think we are a dying breed because  
2        people see that as their job, that as their role whereas social workers  
3        take on everything that isn't anybody else's job [laughs] That's their  
4        remit. They don't really shift outside of that "*oh it's not my job*" the  
5        amount of times I've heard "*it's not my job. I'm a nurse, it's not my job*" I  
6        say "*well I could equally say I'm a social worker, it's not my job, but*  
7        *technically if we're wanting to help this person get better, it's got to be*  
8        *done somebody's got to do it*".

Here Nell presents herself as belonging to a 'dying breed' because she is a 'generic person' (line 1). Using a contrast structure, Nell portrays non-generic people as having a clear 'remit', whereas social workers 'taking on everything that isn't anybody else's job'. She illustrates this claim by using active voicing to describe an interaction with a nurse. Again a contrast structure is used to present a nurse as unable to 'shift outside' this clear remit whereas the social worker will do anything that will help the service user 'get better'. Thus, only the social worker is engaged in the 'real work' of supporting a service user in distress. Later in the interview, Nell stated that it is this 'real work' which keeps her 'coming to work every day' (line 6 below).

1        Nell: I don't really want to be in loads of meetings and err policies and  
2        procedures and tangled up in all of that. I love hands on face to face stuff  
  
3        Lisa: And is that what keeps you in the job, keeps you motivated?  
  
4        Nell: Yes. Yes the thought that if you weren't there to stop these things,  
5        they'd not get done or they'd not get noticed yes that's kept me coming  
6        to work every day.

Here then, filling in the gaps left by other professions, doing the unnoticed (line 5) or the invisible-to-other-professions, is intrinsic to 'hands on face to face' real social work (line 2).

Eva also talked more about this notion of social work as not having clear boundaries and as filling in the gaps:

1       Eva: It's a job about so many hats, isn't it? It is quite difficult to say what  
2       we do and err perhaps you get the feeling that what we do is paper up  
3       the gaps in all the other professionals the bits that are complicated or  
4       tricky that's the bits that "*oh we'll get the social worker to do that*" and  
5       that's what we do [laughs]

6       Lisa: [laughs]

Eva presents social work as difficult to define (line 1). Instead, the role of social work is portrayed as to 'paper up the gaps' between the roles of other professions by taking on all the more 'complicated or tricky' work. Eva uses humour and active voicing to emphasise her point. My shared membership means that I too find this funny. Like Nell, Eva contrasts social work with other professions:

1       Eva: I think another thing is when we assess people we tend to take on  
2       all their problems whereas perhaps if it's a nurse I mean I was talking to  
3       a nurse the other day and I was saying I'd gone down with someone who  
4       was having a benefits review because they're doing that with everybody  
5       now umm for the DLA and umm she said: "*oh*", she said: "*yeah, one of*  
6       *mine was written to and because they didn't reply to the letters they've*  
7       *been taken off all their benefits*". And then she went back to doing  
8       whatever she was doing. Well I was horrified because for me if my  
9       patient told me that I'd be: "*right, let's do the forms, let's fill that out*"  
10       and for her, She said "*oh it's awful isn't it?*" and for her it wasn't and  
11       she's a lovely lady and in terms of what her role is she's really you know  
12       caring she just for her it would not occur to her that might be something  
13       that she could do and her patient has probably told her this and she'll be  
14       there going: "*oh that's awful, god that's terrible*" but never have said "*go*  
15       *on, get the forms out then. I'll help you with them*". I mean there are  
16       some nurses who are much more you know into it but as a general thing.  
17       And saying that there are some social workers who are not doing  
18       anything as well. There's an element of personality in this isn't there,  
19       what's going on in people's lives, I think.



This atrocity story is used to demonstrate the differing responses to the needs of service users by nurses and social workers. In a contrast structure, a social worker will 'take on all their problems' (line 1-2) whereas 'it would not occur' (line 12) to the nurse that she could take on a task which she would see as outside of the nursing role. The depiction of the nurse as a 'lovely lady' (line 11) and 'caring' (line 12) means that her lack of action cannot be explained in terms of her being uncaring or unkind. The nurse is positioned as blinkered and lacking in awareness of anything outside of the nursing role (line 12); only the social worker is aware of the complete picture. This atrocity story echoes the points that Eva has made earlier that social work is without clear margins and boundaries. In contrast, the nurse has a clearly defined role and the social worker is presented as filling in the gaps left in between the boundaries of all the other professionals in the CMHT. In addition, in the story Eva takes a proactive stance compared to the passive response of the nurse, thus affirming the idea of social workers as assertive. The use of active voicing, asides, and the artful way Eva changes tenses within the story, make this a powerful atrocity story. At the end of her reply, Eva acknowledges that that not all nurses are like this and that some social workers act in this way; that personality has an influence on the way professionals act.

This section of the chapter has argued that social work is intangible. The interviews endorsed the findings of the Interim Report of the Social Work Taskforce (2009) that even social workers find it difficult to define social work or articulate what it is that social workers do, other than filling in the gaps left by other professions. This feature has been reflected in recent changes in the national organisation of the profession. One of the recommendations of the Social Work Taskforce was to set up a College of Social Work to act as the 'voice' of the profession and promote clarity and coherence about the role of social work. The College was launched in January 2012 and the organisation's first permanent Chief Executive, Annie Hudson, joined in August 2013. However, there have been some difficulties, not least being involved in a public argument with the British Association of Social Work (BASW), the largest

professional association for social work in the UK. In September 2012, after two years of discussions, it became apparent that the two organisations had failed to negotiate the terms of a proposed merger. None of the social workers interviewed for this research project were members of the College and they were less than impressed with the fallout with BASW. Ed, for example, couched this in humorous terms:

Ed: It's a bit like the Socialist Revolutionary Party having an argument with the Social Revolutionary Party [laughs] they just can't get it together.

It remains to be seen if the College are able to meet their objective of promoting clarity and coherence about the role of social work. The next section will explore another theme identified from the interviews: the notion that social work is intrinsic to the self.

### **3.4 Social work as intrinsic to the self**

The focus of this section is on a key theme from the interviews that social work is somehow intrinsic to the self. This is encapsulated in the words of Malcolm Payne:

...every social worker, every time they are doing social work: they represent social work, they become, embody, incorporate, they *are* social work. (Payne 2006 p.55)

The section will be divided into two: becoming a social worker and being a social worker. First, there will be an examination of the theme from the interviews that there is a congruence between an individual's personal and social work identity which exists prior to becoming a social worker. This appeared to be the 'proper' response when explaining the motivation to become a social worker. Secondly, the notion that social work is intrinsic to the self will be examined in some more depth through the analysis of extracts from two of the interviews.

### 3.4.1 Becoming a social worker

Many of the social workers portrayed their personal and their social work identity as congruent and that this existed prior to becoming a social worker. Indeed, this was the 'proper' answer to the question about becoming a social worker. For example, Olivia replied that 'I think I was actually destined to be a social worker really'. Later in the interview, Olivia returned to this theme of being 'destined' to become a social worker:

- 1 Olivia: I think it's what I'm meant to do [indistinct] I feel a bit geeky
- 2 about it. I'm like a geek social worker.

Here Olivia depicts social work as 'what I'm meant to do'. Like being 'destined' this places her as somehow preordained to become a social worker. Earlier in the interview, Olivia presented her personal values and social work values as congruent.

- 1 Olivia: You know if people yeah if people ask me what I "*what do you*
- 2 *do?*" "*I'm a social worker*" I'm very sort of proud of it and it very sort of
- 3 very much because of my value base and the value base you're meant to
- 4 have as a social worker I think marry quite well together.

Here Olivia described already having the value base that a social worker is 'meant to have' and that her own value base and the social work value base 'marry quite well together'. Rose also discussed this congruence:

- 1 Rose: I think that's reinforced now because a lot of what I do what
- 2 you're told you should be doing this is what I would do anyway in terms
- 3 of working with people
- 4 Lisa: And so it fitted in?
- 5 Rose: Yeah yeah yeah.

For Rose, her approach to service users was intrinsic; what she was 'told you should be doing' in social work training was what she 'would do anyway'. My question that

there was a 'fit' between her personal and social work values is fervently endorsed through repetition ['Yeah yeah yeah'].

In the interview with Grace she maintained that a person needs to possess certain inherent qualities in order to become a social worker.

1 Grace: I think that [pause] I think that inherently you have to have an  
2 interest in people. I think you have to have a genuine [pause] how do I  
3 describe it? You have to want to see people within their own lives. You  
4 have to want to see people live a life that they feel meets their needs. I  
5 think you have I don't know I just think you have to be interested. I can't  
6 say it enough. You know I take students [pause] I lecture second and  
7 third years BA Honours students and things like that and you can see in a  
8 room the people that you look and think: "*I really hope that you're going*  
9 *to raise your game*". It's got nothing to do with an academic interest. It's  
10 to do with a real drive. Do you know what I mean?

11 Lisa: Definitely

12 Grace: You know I'm lucky that I'm in the position the people who come  
13 here as students I can I'm very clear with people I can really forgive  
14 ignorance and I can really forgive huge gaps in knowledge. If the person  
15 doesn't come with a real sense of you know I am working in such a  
16 responsible role with people and my influence can be so huge that you  
17 need to respect that. If they don't come with that then my alarm bells  
18 are already going off. I already I just think [pause] you know if that  
19 ability to write somebody off really quickly.

Here Grace describes the necessity for a student social worker to have an 'inherent' and 'genuine' interest in people (line 1-2). She makes a distinction between this 'inherent' interest and an 'academic' interest (line 9). Indeed the students can have huge gaps in their understanding if they have this inherent interest, the 'real drive' (line 10). Grace portrays herself as able to see which students have this 'genuine' interest and which students need to raise their game (line 9). This is almost on a tacit level; she can 'see' them in a lecture hall (line 7). Grace describes her 'alarm bells' as going off if they do not have these inherent qualities but instead have the 'ability to write somebody off really quickly' (line 18-19). Grace's position that a social worker

needs to have these inherent qualities was affirmed elsewhere in her interview when she described the social workers who had been key in her social work career.

### 3.4.2 The importance of key people

Several of the social workers talked about people that had been important to them when they were becoming a social worker. As already mentioned, Grace discussed the 'pivotal people who have shaped the way I hope I am'. As with the student social workers, Grace distinguishes these social workers as having a 'genuine interest':

1 Grace: And I think you can pick that up from people who have a genuine  
2 interest. You can see them, they're interested in people, they're got a  
3 umm they've got an inquisitiveness that just [pause] it goes beyond  
4 work, I can't describe it it transcends beyond nine to five, they yeah I  
5 can't really quantify it but you can feel it.

Again these qualities are portrayed as going 'beyond work' and as inherent to the person. Once more this is tacit knowledge; it is not quantifiable but 'you can see them' (line 2) and 'you can feel it' (line 5). These are 'real' social workers. In contrast, 'non-genuine' social workers are presented as lacking this interest:

1 Grace: I think I can see throughout my career. And they were people  
2 who you I think you can see especially with social work people who have  
3 to they process but there doesn't come any empathy or there doesn't  
4 become a vibe. They don't have, it's not, it doesn't come across as being  
5 real a real interest in community and cohesion and people and  
6 acceptance and things like that.

Grace presents these non-genuine social workers as lacking 'empathy', a 'vibe' (which links with the tacit), and an interest in 'community and cohesion' and 'people and acceptance'. Thus, by contrast, genuine social workers do have an interest in these areas. Like Eva, Grace is defining 'real' 'genuine' social workers. When talking about social work training, Grace returns to this issue of the key people who have inspired her.

1 Grace: I think I was looking back I was inspired by one or two particular  
2 people who as an experienced practitioner now looking back I think that  
3 cut them in half they were social workers through and through. They  
4 oozed it. They were good examples of values and they brought that very  
5 much to the lectures. I think other people didn't push that much. It  
6 wasn't intrinsic. It was like a bolt on.

For Grace these key people were intrinsically social workers: it is so fundamental to their identity that 'cut them in half they were social workers through and through. They oozed it'. For Grace, these key people epitomise what social workers should be. In contrast, for non-genuine social workers, social work is not intrinsic to their identity but instead is 'like a bolt on' (line 6).

Ed also made a similar distinction when he was talking about his placement supervisor [now called practice educator] on his first placement. Ed described having a 'very bad placement supervisor' who 'wasn't coming from a social work background'. However, his secondary supervisor 'stepped in and she kind of salvaged it, you know, and it was really down to her that I got through it to be honest'. Ed compared the two supervisors:

1 Ed: just that exposure to someone who's very good, who's very, who has  
2 a very good human touch with people, that's what you need. You know  
3 when you get thrust into these situations with people who are basically  
4 very poor at those sort of [pause] those sort of qualities, that's when I  
5 think that people get disillusioned [pause] you know. Because it's not all  
6 about just getting a job. It's there's a slight kind of vocational side to  
7 social work, isn't there?

8 Lisa: Yes, yes

9 Ed: Where you kind of agree with the ethics, agree with the values, you  
10 agree with the history, where its roots are and it's about wanting to do, I  
11 suppose, useful work within the community, isn't it? And if you're  
12 starved of that exposure to those sorts of qualities then it just is a job.  
13 You know, it just is this sort of quite mundane experience, isn't it? I think  
14 those are the things that enrich it, aren't they, you meet those sort of  
15 people.

- 16 Lisa: Yes. So even though she wasn't a social worker, in a sense she had  
17 all those social work
- 18 Ed: She encompassed all those values. And I was kind I think that was the  
19 main reason. I think very highly of her still to this day because she sort of  
20 did a social work job on me
- 21 Lisa: Yes, yes [laughs]

In this extract, Ed contrasts the two supervisors: the second supervisor is depicted as having a 'very good human touch with people' (line 2) whereas the original supervisor is 'basically very poor at those sort of [pause] those sort of qualities' (line 4). In a similar way to Grace, Ed contrasts social work *as a vocation* with social work *as a job*. The second supervisor epitomises social work as a vocation where 'you kind of agree with the ethics, agree with the values, you agree with the history, where its roots are and it's about wanting to do, I suppose, useful work within the community' (lines 9-11). For Ed, this is 'real' social work. In contrast, the original supervisor epitomises social work as a job where 'it just is this sort of quite mundane experience' (line 13). In another contrast structure, Ed compares being 'starved of that exposure to those sorts of qualities' by the original supervisor (line 12) with being enriched by the second supervisor (line 14). What is interesting here is that even though the second supervisor was not a qualified social worker, she 'encompassed all those values' (line 18) and she 'sort of did a social work job on me' (line 20). Thus again Ed is demonstrating that it is not solely social work training that engenders these values but is intrinsic to the self.

This section has discussed the importance of key people in becoming a social worker and the theme of social work as intrinsic to the self. These key people epitomised real social work; they 'oozed it', even if they were not actually qualified as a social worker. The focus of the next section is on social work students.

### 3.4.3 Students as marginal natives

The contention in this section is that students can be seen as ‘marginal natives’, an ethnographic term where a person is ‘poised between familiarity and strangeness’ (Hammersley and Atkinson 1995 p.89). In his ethnography, Pithouse (1984 p.29) described the student social workers as ‘marginals’ on the periphery of office relationships. In a footnote, Wieder (2004 p.203n) discussed how both he and new staff members ‘strove to make the scenes of the halfway house familiar to use in such a way that they were progressively experienced as more and more complex, elaborate, definite, seeable-in-a-glance, and within our control’.

In ethnomethodological terms, students have not yet developed the deep competence of vulgarly competent members. They are not able to ‘see’ the invisible as they have not embodied the ethnomethods of social work. This means that questions from students are sanctioned. For example, Paul used active voicing in an interaction to depict students as asking the ‘most pertinent questions’:

Paul: I think umm students always ask the most pertinent questions like “*what’s the difference between you and a CPN [Community Psychiatric Nurse] apart from giving them a depot?*” and you kind of go “*err*”.

It is notable that it is students who are described as asking these questions; a competent member of the social work and nursing profession would very much be aware of the differences. Later, Paul talked about how taking on a student ‘refreshed’ him in terms of his social work identity (line 5 below).

1 Paul: And then it you kind of come in to the work and if you’re lucky  
2 enough your supervisor may still bring in that reflective edge or value  
3 based edge but it soon becomes apparent that it’s forgotten and it’s  
4 managing your cases and stats and targets and all of that is forgotten. So  
5 personally I found taking on a student refreshed me, you know, I was  
6 able to revise all the values whereas and I learnt a lot from the student  
7 as well, you know, because you kind of go back to the beginning again.  
8 And in my opinion all social workers if they can, you know, should have  
9 the opportunity of working with a student because it kind of grounds you



10 again and brings back that identity otherwise you are kind of lost in the  
11 day to day management managing the cases yeah

12 Lisa: So you found having a student strengthened your identity?

13 Paul: Yes absolutely and doing some teaching as well because again  
14 obviously I had to demonstrate that I actually knew what I was talking  
15 about [laughs]

Paul describes how the reflection and value base of social work is 'forgotten' in practice; a word he repeats twice (lines 3 and 4). Instead the emphasis is on managing bureaucratic requirements ['your cases and stats and targets']. In taking on a student, Paul had to 'go back to the beginning again' in order to make social work visible to the marginal student (line 7). In ethnomethodological terms, the accomplishment of social 'work' had to be made exhibitable, observable and reportable (Garfinkel and Sacks 1970) to the marginal member. Description is not a member's concern *except for the purposes of instructing* (Rawls 2006 p.92 italics mine). In other words, a member engaged in the on-going accomplishment of an interaction is not concerned with providing an analogous description or commentary on what is happening unless s/he is instructing another person in that activity. Having a student and going back to the beginning 'grounded' Paul, bringing back his social work identity rather than being 'lost' in bureaucracy (lines 9-10). This also happened through teaching when Paul again had to demonstrate aspects of 'invisible' social work to marginal students (line 13). I returned to this issue later in the interview with Paul.

1 Lisa: Which is good that you said that you think people should have a  
2 student because it brings those tricky questions like "*what is social*  
3 *work?*"

4 Paul: Because social workers seconded to a trust and in predominantly  
5 psychiatry and medical model and more increasingly more and more  
6 managers coming from a nursing background over time it will be lost and  
7 you will probably I don't know but we may be greeted with looks of  
8 bafflement if we said "*well where's the social work models and*  
9 *theories?*" That's another point you know only when students come  
10 along do I think about theory and models of working [both laugh] Social

1 work models if I were to bring that to a team meeting led by a  
2 psychiatrist and a nurse a senior nurse practitioner I'd probably be  
3 looked at "*what are you talking about? Just get on with it*". And that's a  
4 shame.

Once again, Paul portrays social work identity as being 'lost' as a result of working within a 'predominantly psychiatry and medical model' and as increasingly being managed by nurses (line 6). Paul argues that social work models and theories are treated with 'bafflement' and derision [*"what are you talking about? Just get on with it"*] within this health dominated environment. Again, it is only by having a student that Paul actively thinks about social work theories and methods (line 9).

To conclude, students are not yet fully competent members and need to be instructed in how to see the invisible social work. For those social workers who act as a practice educator, having to make social work visible to students means that the values, theories and methods 'lost' in practice are re-established, reaffirming social work identity. The final part of this section concerning social work as intrinsic to the self will explore this theme further using extracts from two of the interviews.

### **3.5 Being a social worker**

The notion that social work is intrinsic to the self will now be explored further through an analysis of this theme from two of the interviews. The first interview is with a social worker who I have called Andrew.

#### **3.5.1 The interview with Andrew**

Andrew's reply to my opening question about how he first became interested in social work was that it seemed 'like a natural thing to me' (line 5 below).

1 Andrew: I was originally going to do my nursing course but found the  
2 concept of working on a ward horrific. And I umm always been really  
3 interested in politics and things like that and I was quite left wing and

4 into protesting and things like that when I was younger so it kind of  
5 seemed like a natural thing to me

6 Lisa: Yeah. And so had you heard about social work, through your work  
7 was it?

8 Andrew: Yeah, I'd met social workers. There'd been people who were  
9 doing bank work where I was working that were doing the social work  
10 degree and then a chap came who is one of my best friends now who  
11 was actually doing his mental health nursing degree and he started it. He  
12 started it, or he was going to start it the year after and he was like, "*go*  
13 *on, why don't you do it, why don't you do it?*" and I was just "*no, no, no,*  
14 *no*" but yeah, of course I should do it but I did an access course first  
15 because I had left school without any qualifications at all, I left school at  
16 fourteen with nothing so umm I did an access course first and that kind  
17 of spring boarded me to doing the degree

18 Lisa: But it's interesting, isn't it that you could have done the nursing but  
19 you there's something about was there something about the social work  
20 that you

21 Andrew: Yeah, I've never really been into authority or anything like that  
22 hence the no qualifications and I'd done voluntary work on wards quite  
23 for quite long periods of time. And I'd found that hierarchy between the  
24 nurses and the sisters, doctors I found it really very difficult to tolerate  
25 and umm I did a bit of bank work doing as an HCA [Health Care Assistant]  
26 on wards and I could see the hierarchy and it just, you know, so it was  
27 really only a brief kind of umm flirtation with doing nursing. And then I  
28 remembered what it I remembered whether it was that I was going to  
29 mental health nursing or umm general nursing that I'd have to cut my  
30 teeth on the wards and that was just no. No way, no way

31 Lisa: And what was it about the social work that you thought would be  
32 different to that?

33 Andrew: Well, it appealed to my sense of interest in sort of sociology in  
34 general but politics it seemed more political it seemed more left wing. At  
35 the time, not sure whether it's like that now but umm it seemed like it  
36 seemed to fit my ideological way of thinking much more than the clinical  
37 aspects of nursing. It was more umm it was more it seemed more  
38 abstract umm rather than routine, than fixed, you know, and it really  
39 seemed to fit my brain a lot better. Yeah.

In his reply Andrew distinguishes between training to become a social worker and training to become a nurse. Whereas training to become a nurse on a ward was

'horrific' (line 2), training to become a social worker was 'natural' (line 5). Here Andrew associates social work as connected with being 'really interested in politics' and being 'quite left wing' and 'into protesting' (lines 3-4). In his next reply, Andrew uses active voicing to depict one of his best friends, a mental health nurse, strongly encouraging him to train as a nurse [*"go on, why don't you do it, why don't you do it?"*] with his equally strong refusal [*"I was just "no, no, no, no"*]. My comment implicitly demonstrates that I have recognised this notion that social work is 'natural' for Andrew, which I then immediately re-frame into a question [*'there's obviously something about was there something about the social work that you'*]. Again Andrew presents social work as associated with being anti-authoritarian (line 21). In contrast, nursing is hierarchical (and so authoritarian) which he found 'really very difficult to tolerate' (line 24). In the coda to this reply, Andrew reiterated that he could not work on the wards, using repetition to emphasise the strength of this view [*'I'd have to cut my teeth on the wards and that was just no. No way, no way'*].

In his next reply, Andrew again portrays social work as associated with being 'political' and 'left wing' (line 34). Finally, Andrew depicts social work as congruent with his 'way of thinking' and his 'brain': 'it seemed to fit my ideological way of thinking' (line 36) and 'it really seemed to fit my brain' (line 39). Thus, once again, social work is presented as intrinsic to the self. Again, Andrew directly contrasts nursing and social work - social work is 'ideological' (line 36) and 'abstract' (line 38) whereas nursing is 'clinical' (line 36), 'routine' and 'fixed' (line 38). Like Eva, Andrew is delineating what is 'real' social work. My next question moved the focus of the interview on to the topic of social work training.

1 Lisa: That's good. And when you went into the training, did you find that  
2 it was how you'd seen it did you find that social work was as you'd  
3 thought it was?

4 Andrew: Yeah, absolutely, I got it hook, line and sinker really, you know I  
5 really did. Umm, err, you know, some of my friends who were nurses  
6 would kind of ridicule me really you know

- 7 Lisa: [laughs]
- 8 Andrew: They used to call me the social sniffer
- 9 Lisa [laughs]
- 10 Andrew: You know and [laughs] and things like that because I really and  
11 it was kind of there but the whole concept of social justice and things like  
12 that. That you know kind of the marginalisation process that happen  
13 within society it was kind of like I knew that they were all there. But it  
14 was quite unfocused and I didn't sort of academic and theoretical point  
15 of view really know that I didn't really know how they were structured so  
16 I kind of really I still today kind of I bought right into it
- 17 Lisa: Right, umm great. So people were kind of laughing at you for that?
- 18 Andrew: Yeah woolly tree hugging social worker
- 19 Lisa: [laughs]
- 20 Andrew: Yeah it's just all the usual clichés and stereotypes I didn't mind.  
21 I didn't mind them viewing me as that at all really. Yeah

In a key phrase illustrating the theme of social work as intrinsic to the self, Andrew states that: 'I got it hook, line and sinker really, you know I really did' (line 4). This idiom, which alludes to fishing, means that the person fell for something utterly and completely: not just swallowing the 'bait' (the hook) but the entire fishing equipment (the line and the sinker). It is curious that Andrew uses this to describe becoming a social worker as the phrase is usually used to describe a person that has been 'gullible' and fallen for a ruse or a trick. Indeed Andrew goes on to describe his nurse friends as ridiculing him (line 6). Here I laugh at this 'laughable', an invitation to laughter. In another laughable Andrew describes the nurse friends as calling him the 'social sniffer' (line 8). Again, this is an interesting choice of words. Obviously, the 'social' is the key part of social work; the 'sniffer' part associates with sniffer dogs who are engaged in detection. Taken as a whole it seems to correspond to a person who interferes in people's lives; being a snoop or busybody. The latter are common derogatory descriptions of social workers although the term 'social sniffer' seems a fonder, more affectionate phrase. Andrew laughs too (line 10) which

demonstrates that he was not offended by this description. For Andrew, knowledge of concepts such as social justice and the marginalisation process pre-existed [‘it was kind of there...I knew that they were all there’] albeit in a ‘quite unfocused’ way. It was through social work training that enabled him to develop an ‘academic and theoretical point of view’ of how these concepts are structured. In another key phrase which aligns with ‘I got it hook line and sinker’ Andrew describes that ‘I bought right into it’ (line 16). Like Ed above, this portrays social work as a vocation and not simply a job. Andrew depicts himself as already ‘naturally’ predisposed to the social work way of thinking and seems to be asserting that during the training he became totally immersed in a social work identity. In reply to my question, Andrew produces another laughable; his friends’ description of him as a ‘woolly tree hugging social worker’ (line 18). My laughter demonstrates that I have recognised that this is a laughable and not troubles-talk (Jefferson 1984); and Andrew validates this view through talk [‘I didn’t mind. I didn’t mind them viewing me as that at all really. Yeah’]. Thus rather than being offended at these ‘clichés and stereotypes’ (line 20), Andrew finds them funny, suggesting that he is secure in this identity as demonstrated in the strong affirmation. Later in the interview, Andrew returns to talking about social work training:

- 1 Andrew: And this is going to sound a bit lofty but I think that training it’s
- 2 like you’re breathing you don’t know you’re breathing, but you know it’s
- 3 there. Ok, so all of that stuff you get taught just sits there in your brain
- 4 and it should direct everything that you do and it should eventually
- 5 become second nature, really

Andrew’s reply contains two more key phrases from the theme social work as intrinsic to the self. Firstly, social work becomes as fundamental or as natural as breathing [‘it’s like you’re breathing you don’t know you’re breathing, but you know it’s there’]. In the second key phrase, social work becomes embodied [‘all of that stuff you get taught just sits there in your brain and it should direct everything that you do and it should eventually become second nature’]. Social work is so intrinsic to the self that it is like breathing; is embodied, directing ‘everything that you do’;

becoming 'second nature' (i.e. it is so very natural). Rawls (2006 p.5) argued that 'actors themselves, while in the natural attitude, take these details for granted and thus are not aware of the details of the practices they enact'. In the final excerpt from the interview with Andrew, he is talking about nurses being able to become AMHPs. I ask if he thinks that the competences required to be an AMHP remain social work values:

1 Andrew: Yes and I think that's still imbued within the Mental Health Act  
2 that's why it's hard really though it's difficult to get values in a legal  
3 prescription, you know, they are there really and it's that thing about the  
4 relationships with the health trusts and I think, that worries me.

5 Lisa: About being independent, not being independent?

6 Andrew: The level of independence and the, it's attitudinal as well, you  
7 know, illness focused umm "*it's obvious someone needs to be sectioned,*  
8 *isn't it?*" you know, but it doesn't preclude you from seeking  
9 alternatives. Some people are obviously very very ill and need to be in  
10 hospital but it's that thing about what's running in the background all the  
11 time, what you should be thinking all the time, you know, and I think  
12 that's what's missing, really from them.

Again Andrew is comparing nurses and social workers but does not have to spell this out, rather it is expressed indexically. He begins by portraying nurses as less independence and as working within the medical model. Whilst nurses are illness focused and automatically think that someone should be 'sectioned' [admitted to hospital using section 2 or 3 of the Mental Health Act), social workers 'seek alternatives' (line 7-8). Here Andrew is referring to the duty of an AMHP to look for alternatives to hospital admission. The Code of Practice (2008 4.51) states that the role of AMHPs is to 'provide an independent decision about whether or not there are alternatives to detention under the Act, bringing a social perspective to bear on their decision'. Andrew presents thinking about alternatives to admission as intrinsic to the social work self: it should be 'running in the background all the time, what you should be thinking all the time' (line 10-11). It resonates with his earlier phrase about social work as sitting there in your brain, directing everything that you do. The

coda to the reply is that this is missing from 'them' (line 12): again this is an indexical expression but we both know he is referring to nurses.

This analysis of extracts from the interview with Andrew has endeavoured to illustrate the theme that social work is intrinsic to the self. The final part of this section will now expand on this theme through an analysis of extracts from the interview with John.

### 3.5.2 The interview with John

In line with the 'proper' or 'correct' answer to the question about wanting to become a social worker, John described himself as *always* socially minded, *always* fair minded, wanting the best for someone and being angered by prejudice (Lines 2-4 below). The repetition of the word 'always' serves to emphasise that these qualities are an intrinsic part of John's identity.

- 1 John: I'm saying why I came into social work but I think that was mainly I  
2 was always socially minded, always fair minded and wanting the best  
3 and get quite cross when anybody's been prejudiced in any way umm  
4 and that I suppose was the beginning.
- 5 Lisa: So it sounds as if you had all these things and like you say they all  
6 came together in the social work theory so you really seemed to have  
7 got grounding in where social work fits in with all these other subjects?
- 8 John: Yes. And what I find difficult now is because it's all absorbed and in  
9 there [pause] I always remember because I've been a practice teacher  
10 for many years though I haven't had a student well I've had ASW  
11 students but I haven't had err a university student for a little while  
12 [pause] and we'd jump in the car it was in the early parts of the  
13 placement and I'd say "*oh I'm just going off to see so and so for a chat*"  
14 "*A chat?*" "*Yeah, yeah*" "*What do you mean?*" then I had to dig it all out  
15 the whole what I'd be looking for "*Well I'm going to see what the*  
16 *environment's like*" you know. But things that's so enmeshed within you  
17 that you just do it you know it becomes it's a little bit like when you're  
18 learning any new sport like golf you've got to keep your head down  
19 you're got to swing properly and what have you and when you're good  
20 and I'm not good and I'm not saying that because we all need to be



21 better but it just becomes you don't think about it it's second nature and  
22 in a similar way with social work that's what it's become for me really.  
23 Umm I can do it it just needs digging out.

My comment (line 5) acknowledges this portrayal of these qualities as intrinsic ['it sounds as if you had all these things']. In another key phrase in keeping with the theme of social work as intrinsic to the self, John states that: 'it's all absorbed and in there' (line 8-9). Again, this depicts social work as embodied. Like Paul, John goes on to make the connection that having a student who is a marginal native or member requires social work to be made visible. John illustrates how difficult this can be with a story about a student who questioned what he meant by 'a chat' with a service user (line 13). As Cath stated earlier, what to an outsider may look like a 'chat' is 'work' to a social worker; the outsider 'cannot 'see' what the worker wishes to be 'seen'' (Pithouse 1998 p.5). John describes how he had to 'dig it all out the whole what I'd be looking' (line 14); in other words, it is so intrinsic that it needs to be excavated. In another key phrase John describes social work as 'so enmeshed within you that you just do it', using the example of learning to play golf (line 16). Social work has become 'second nature' (line 21), not requiring any thought ['you don't think about it']. This strongly resonates with the words of Coulon (1995 p.27) that once 'they are affiliated, the members do not have to think about what they are doing...[but] 'naturally' exhibits the social competence that affiliates her with this group'. John then reiterates that it needs 'digging out' (line 23) if it is to be made visible.

In another extract, John returns to the notion that he was predisposed to become a social worker:

1 John: I suspect I suppose a lot came from myself umm also working at  
2 [name] there were lots of other social workers there who were steeped  
3 in mental health so that was a help although to be fair I did my  
4 qualification before I went there. Umm but yeah it was difficult and it's a  
5 hard thing to do ASW or AMHP as it is now because I finished the course,  
6 got my ticket and I was on the rota, I was out on my own, that was it.  
7 Whereas now even when they've qualified we shadow them for a good

8 six months before in fact the last two we shadowed them for about a  
9 year.

10 Lisa: Did you?

11 John: That was only because they kept saying "*I don't want to do it yet*  
12 *on my own*". But they're both now fully blooded.

In this extract John describes becoming an Approved Social Worker [the former name for an AMHP]. Although 'a lot came from myself', this transition was aided by being with other social workers 'who were steeped in mental health' (line 1-2). The word *steeped* echoes the words *absorbed* and *enmeshed* he has already used to once again display social work as intrinsic to the self. Finally, John uses the term 'fully blooded' to describe the social workers once they had become full AMHPs (line 12). Again, this phrase suggests that once the AMHPs had completely taken on this role it had become embodied as part of their 'blood'. Like Andrew, then, John presents social work as intrinsic to the self.

This section of the chapter has been concerned with the theme of social work as intrinsic to the self. The section began with an examination of the notion that there is congruence between an individual's personal and social work identity which exists prior to the person training to become a social worker. Next, there was a discussion of the notion that students are 'marginal natives'. Their marginality requires social workers to leave the natural attitude in order to make social work visible. Following this, the importance of key people in epitomising social work was examined. The final part of the section explored the theme that social work is intrinsic to the self in more depth by analysing extracts from two interviews.

### 3.5.3 Jelly babies?

However, it is important to point out that 'real' social workers are not identikit but are able to be different. Grace talked about this in her interview:

1 Lisa: Are you still the only social worker?

2 Grace: No I pushed for another social worker, got another social worker,  
3 so there's two of us. I'm an AMHP and he's doing his AMHP training.  
4 Yeah we are quite a strong we're very very different. Umm personalities  
5 are very very different. Ethically we're very very different so it's a good  
6 combination.

7 Lisa: And gender

8 Grace: We've covered every base [laughs]

9 Lisa: [laughs]

10 Grace: We often laugh about it. Yes he's good to have on board. We're  
11 very different personalities but

12 Lisa: And would you say he's a strong social worker as well?

13 Grace: [pause] I would say that [pause] as a personality he's a very gentle  
14 man and his knowledge base and his ability is brilliant. At the time I was  
15 aware he worked in another team and we were asked if we'd like to  
16 have another AMHP and I said that it didn't warrant two AMHPs there  
17 wasn't enough work but I was happy to take him on because of what he  
18 brought. Again, going back to that original thing, a really passionate man  
19 compassionate with patients and clients. So he came with all that so I  
20 was prepared to compromise on I'm a bit more forceful. I'm a bit more  
21 vocal. I'm probably more challenging to the doctors than he is. Yeah.

Here Grace describes how different she and the other social worker are; indeed, she repeats the phrase 'very very different' three times in her first reply (lines 4-5). Whereas Grace presents herself as more forceful, vocal, and challenging to the doctors (lines 20-21), she describes the other social worker as a very gentle man with a brilliant knowledge base and ability (lines 13-14). However, despite these differences, the other social worker has the qualities ["he came with all that"] that Grace has already discussed as necessary; he is 'a really passionate man compassionate with patients and clients' (lines 18-19). Thus, although there are some differences, he shares these fundamental qualities.

Olivia also talked about this notion that social workers are not all the same in her interview:

1 Olivia: It's not like we're all jelly babies and we have to fit this mould. We  
2 each bring something different. I think if they wear lots of wool, Clark's  
3 shoes, read the Guardian and drive a 2CV then we're part way there  
4 [laughs] but actually I think that's a bit outmoded. I think actually there's  
5 a I mean I've met really good social workers who might even vote  
6 Conservative and that to me blows my mind but umm it's something  
7 about someone's presence and their attitude, I think, and their umm I  
8 think it's a people thing. It's about communication, holding someone in  
9 unconditional positive regard and that's that has to be almost an innate  
10 quality really in social work.

Thus, rather than being 'jelly babies' or conforming to the stereotypical ideas of what a social worker should be like, social workers 'each bring something different'. However, like the other AMHPs above, Olivia portrays social workers as having to have 'almost an innate quality' (line 9-10). This is inherent to their 'presence' and 'attitude' (line 7); is about 'people'; 'communication'; and 'holding someone in unconditional positive regard' (line 8-9).

Thus, both Grace and Olivia contend that social workers can differ but there are some fundamental and intrinsic qualities that must be present in order to be a 'real' social worker.

### **3.6 Conclusion to chapter**

The focus of this chapter has been on 'real' social work. The chapter began with a discussion of Eva's depiction of the 'treasured' and the 'rubbish'. Through her talk Eva delineated what is the 'treasured': this is 'real' social work. Real social work portrayed as autonomous, hands-on, invisible 'social' work with service users. For the social workers, real social work involved social change, hands on work in the community, and supporting service users experiencing distress. However, both Eva and Paul estimate that only a third of their time is spent doing real social work; the majority of their time is spent on the 'rubbish', namely bureaucratic requirements. The extracts from Eva and Paul have demonstrated the very difficult circumstances in which mental health social workers are currently working and the emotional

impact that this has on them. It was argued in the following section that social work is 'intangible'. Thus, rather than being a discrete, defined sphere of activity, social work is without clear margins and boundaries, filling in the gaps left by other professions. This intangibility goes some way to explain the ongoing difficulty in providing a clear definition of social work. Finally, in the interviews, 'real' social workers were portrayed as having social work as an intrinsic or inherent quality. This includes personal and social work identity being congruent, pre-existing social work training. The importance of key people as epitomising real social work was also explored in the chapter. In addition, social work identity was presented as being reinforced by having students who are 'marginal natives' as the social workers are required to make visible that which is unseen and taken for granted. Although real social workers are not identikit 'jelly babies', they were described as having certain fundamental and innate qualities.

The discussion of real social work will continue in the next chapter, 'Being an Approved Mental Health Professional'. It will be argued that AMHP work is real social work.

## 4 Being an Approved Mental Health Professional

### 4.1 Introduction

The focus of this chapter is on being an Approved Mental Health Professional (AMHP). The chapter will discuss being an AMHP in two senses of the role. Firstly, the focus will be on the role in a very narrow and specific sense: the duty of an AMHP to undertake assessments to make applications for admission or guardianship under the Mental Health Act 1983. In the second part, the focus will move to a consideration of being an AMHP in a more general sense. Here there will be a concern with AMHP work as involving all the different aspects of being a mental health social worker in a Community Mental Health team (CMHT).

The role of the AMHP in the very narrow and specific sense is the duty of an AMHP to undertake assessments to make applications for admission or guardianship under the Mental Health Act 1983. This duty is enshrined in section 13 of the Mental Health Act 1983 as amended by the Mental Health Act 2007. The specific role of the AMHP is explained in detail in the Mental Health Act Code of Practice (2008) from subsection 4.48 to subsection 4.110. The AMHP has the overall responsibility for setting up and co-ordinating an assessment under the Mental Health Act. This will involve numerous tasks, such as arranging for the two doctors to assess the person; arranging for an ambulance to convey the person to hospital; and deciding whether the police should be present. There is also a legal obligation on the AMHP to attempt to identify the person's Nearest Relative as defined in section 26 of the Act. An AMHP making an application for detention under section 2 of the Mental Health Act must take such steps as are practicable to inform the Nearest Relative that the application is to be made and of the Nearest Relative's power to discharge the patient. In relation to section 3, an AMHP must consult the Nearest Relative before making an application for detention unless it is not reasonably practicable or would involve unreasonable delay. The AMHP also has to consult other people who are involved in the person's life. An AMHP can only make an application for compulsory admission to hospital if they have interviewed the patient in a 'suitable manner'; are satisfied that the statutory criteria for detention are met; and are satisfied that, in 'all the circumstances of the case', detention in hospital is the most appropriate way of providing the care and medical treatment that the person needs. All of these components have been subject to case law; for example, in the case *TTM v London Borough of Hackney East London NHS Foundation Trust* (2011), the Court of Appeal found that an AMHP did not act reasonably in concluding that there was no objection from the Nearest Relative and so the admission under section 3 was unlawful. An important point to note is that although an AMHP acts on behalf of the Local Authority, they must exercise their own judgement, based on social and medical evidence, when deciding whether to apply for a patient to be detained under the Act. The role of AMHPs is to provide an *independent* decision about

whether or not there are alternatives to detention under the Act, bringing a social perspective to bear on their decision (Code of Practice 2008 section 4.51). The chapter will begin with an examination of AMHP work in this very specific sense. This will be delineated by the reference to AMHP *duty* rather than AMHP *work*. This section of the chapter will use research by Everett C. Hughes (1948); Robert M. Emerson and Melvin Pollner (1975); and Phil Brown (1989) to examine whether undertaking this social control function is 'dirty work'.

Following this discussion, the focus will move to a consideration of being an AMHP in a more general sense: being involved in all the different aspects of being a mental health social worker in a Community Mental Health team. As the previous chapters have shown, this is a very wide role involving both the 'rubbish' and the 'treasured' and is notoriously difficult to define. This more general role will be delineated by the reference to AMHP *work* or simply *social work*. The first part of this section will explore some of the implications of being a social worker seconded to a Health Trust. In particular, there will be a focus on the 'visibility' of social work within these teams. If social work is an invisible trade and only made visible through collegiate relationships and in supervisory encounters as Pithouse (1984) has argued, how then can it be made visible where there are no other social workers in the team? Finally, the transition from the role of the Approved Social Work to the role of the Approved Mental Health Professional will be discussed. The Chapter will conclude with a discussion of the future of mental health social work from the social workers' point of view.

## **4.2 AMHP work: dirty or prestigious?**

The focus of this section of the chapter will be on the question of whether undertaking the AMHP duty to make an application for detention in psychiatric hospital is 'dirty work'. First, previous research on dirty work will be reviewed. This knowledge will then be used to investigate the data from my interviews with the AMHPs.

### 4.2.1 Previous research on dirty work

Everett C. Hughes introduced the concept of 'dirty work' in a public lecture at McGill University in 1948. The lecture, 'Good People and Dirty Work', published as a chapter in 1962, followed an extended visit to West Germany and concerned the 'most colossal and dramatic piece of social dirty work the world has ever known' (1971 p.87); the Holocaust. Hughes (1971 p.95) noted that there are *in* and *out* groups; the 'greater their social distance from us, the more we leave in the hands of others a sort of mandate by default to deal with them on our behalf'. Arguably, people with mental health issues are considered to be an out group and it is AMHPs who have been given this social control mandate. In a later article, 'Work and Self' (1951), Hughes explained that every occupation contains a bundle of activities, some of which are the dirty work of that group. He defined several ways in which work might be dirty:

It may be simply physically disgusting. It may be a symbol of degradation, something that wounds one's dignity. Finally, it may be dirty work in that it in some way goes counter to more heroic of our moral conceptions. Dirty work of some kind is found in all occupations. It is hard to imagine an occupation in which one does not appear, in certain repeated contingencies, to be practically compelled to play a role of which he thinks he ought to be a little ashamed morally. (Hughes 1971 p.343)

Hughes (1971 p.340) argued that even in the lowest occupations people develop 'collective pretensions' or 'dignifying rationalizations' in order to give their work, and consequently themselves, value in the eyes of each other and of outsiders. Hughes identified the relevance of the difference between doing something *for* someone and doing something *to* someone. He showed how this can be ambiguous and that the line between them is 'thin, obscure and shifting' (1971 p.305). This is highly relevant to the work of the AMHP. The AMHP might conclude that detention is in the person's best interests; whereas the service user may completely disagree. While people attempt to delegate this dirty work to others, there are some prestigious professions (such as a doctor) in which this is only possible to a limited



extent. Here the 'dirty work may be an intimate part of the very activity which gives the occupation its charisma' (Hughes 1971 p.344).

Robert M. Emerson and Melvin Pollner applied Hughes' concept of dirty work to their study of a Community Mental Health team (CMHT). In a footnote to the first page of the paper, Emerson and Pollner (1975 p.243n) clarify that their focus is on 'dirty work *designations*', rather than simply 'dirty work' per se. Thus, the focus is on the instances in which dirty work is so designated by at least some of the workers involved. The aim of their paper was to explore the nature and meaning of these designations of dirty work for psychiatric workers who staffed the psychiatric emergency team (PET). The staff team consisted of psychiatrists; social workers; psychologists; nurses; and technicians. The role of the team was to respond to emergency calls received by the clinic for either crisis intervention or assessment for hospitalisation. The PET team had the power to order 72 hour involuntary hospitalisation; the only non-medical personnel able to do so. Thus this study is highly relevant to my research. The staff members quickly identified PET activities as a form of dirty work.

On the first day in the field...a psychiatric social worker, deeply committed to the ideals of community psychiatry and for three years a core member of the clinic's PET team, characterized the job to us as "shit work". (Emerson and Pollner 1975 p.245)

Staff identified 'shit work' as work involving the lack of opportunity to help or do anything *for* a client in a therapeutic sense and having to do something *to* them in a coercive sense where the intervention seemed to serve nothing but social control purposes (p.246). Interestingly, in a footnote, Emerson and Pollner (1975 p.246n) argued that this was directly reflected in the PET's use of the terms 'client' and 'patient': client was used when *doing for*; patient was used when *doing to*. The team members identified that their distinctive competence was to use their therapeutic skills to help and care for people. Thus crisis intervention and avoiding hospitalisation was seen as therapeutic work. In contrast, involuntary detention

'stripped away any remaining sense of doing for and made it starkly obvious to all that the patient was being done to [and] were frequently cited as prototypical instances of PET shit work (Emerson and Pollner 1975 p.250).

Emerson and Pollner (1975) identified that there were 'noticeable variations' between different professional groups in the use of the term 'shit work'. Significantly for my research, the term was most 'frequently and vociferously' used by the social workers, the highest status professionals regularly performing PET duties (p.246). The term was less frequently used by the lower ranked paraprofessional psychiatric technicians, with the nurses positioned in-between. Thus, dirty work can be seen as much a function of the perspective of the individual worker as of the inherent qualities of a task. Emerson and Pollner (1975 p.244) concluded that in designating involuntary hospitalisation as dirty work, the worker is declaring 'a kind of moral distance from that dirtiness...[and] reaffirms the legitimacy of the occupational moral order that has been blemished'. As such, they argued that dirty work designations are more likely to be articulated when there are observers present and less likely to be articulated in front of experienced and trusted colleagues.

Over a decade later, Phil Brown (1989) 'revisited' psychiatric dirty work. Interestingly, although the term is not used, Brown described how he became uniquely adequate in the psychiatric setting to the extent that the other staff perceived him to be an integral member of the team. Like Emerson and Pollner's PET staff, the staff in the Community Mental Health team demarcated what they deemed to be 'proper' work. For the staff in Brown's (1989) study, proper work involved the acquisition of good psychotherapy candidates and in-depth intake evaluations. The psychiatric clinic staff considered external nonpsychiatric referrals to be dirty work. The external referrals involved three types of work: seeing homeless people referred by homeless shelters; determining welfare and disability eligibilities; and making pre-release prison evaluations. The staff members in Brown's (1989) study were ambivalent about the social control function. While they

accepted that they were playing such a role for wider society, they recognised that this work was unpleasant and generated a 'dirty label' (Brown 1989 p.189). Brown concluded that it was the threats to the control and autonomy of the team that resulted in this work being designated as dirty as the staff resented the agenda being set by these outside forces. The staff members considered the provision insight-orientated, psychodynamic therapy as the 'best' part of the service and that people needed to come of their own accord. The external referrals and those subject to the social control function were therefore not seen as 'suitable patients'. Brown's research is interesting regarding Emerson and Pollner's assertion that dirty work designations are less likely to be articulated as often in front of trusted colleagues. In this study, Brown was a trusted member of the team but work was still given a dirty label.

Thus, the studies by Hughes (1948), Emerson and Pollner (1975), and Brown (1989) have demonstrated that dirty work designations are more likely when the staff were not engaged in what they deemed to be 'proper' work: namely, therapeutic work with service users. Exercising social control was designated as 'dirty' as it deviated from therapeutic work in being coercive. What the staff members valued was the ability to be autonomous and in control of their work and any work which threatened this autonomy and control was designated as dirty.

Using the insights gained from the work of Hughes (1948), Emerson and Pollner (1975), and Brown (1989), the discussion will now move on an examination of talk about exercising the social control function in my research project. To reiterate, the focus here is on the specific AMHP duty of undertaking assessments in order to make applications for admission or guardianship under the Mental Health Act 1983.

#### 4.2.2 Dirty work designations in the interviews: is AMHP duty dirty work?

This section will explore AMHP work and the possible connection with dirty work in more depth. Social workers in mental health teams cannot undertake the social control function of compulsory detention under the Mental Health Act 1983 until they have trained as an Approved Mental Health Professional. The social worker needs to have been qualified for at least two years before they are eligible to undertake this training. Paul discussed being a social worker in a Community Mental Health team before he qualified as an AMHP.

1 Paul: Before I became qualified as an AMHP I did sometimes have little  
2 moans to myself thinking that there was this kind of self-interested  
3 group, this ASW exclusive group who sometimes appeared quite elitist.  
4 You know “we’re ASWs”

5 [both laugh]

6 Paul: But now I can see why with the work why they protect their own  
7 interests quite strongly.

Here the ASWs [Approved Social Workers: the previous title for the role] are positioned as separate from other social workers with the words ‘this’ and ‘group’ creating a distance (line 2). The ASWs are ‘self-interested’, ‘exclusive’, and ‘quite elitist’ (line 2-3). The use of active voicing, humour, and shared laughter affirms that we both recognise that (some) ASWs presented themselves in this way. Now that Paul is himself an AMHP he has become aware of why AMHPs ‘protect their own interests’, although the use of ‘their’ rather than ‘our’ suggests that he still does not view himself as part of this group (line 6). I return to his point later in the interview.

1 Lisa: So when you did the AMHP training and you said that before that  
2 you used to think who are these ASWs and who do they think they are

3 Paul: Yes [laughs]

4 Lisa: Then you realised that there was quite a lot to it then?

5 Paul: Oh absolutely yeah. It's a you're in a very powerful position for one  
6 umm and that kind of reinforced that sort of concept of power as I last  
7 sort of heard it as a social work student and that was reinforced as well.  
8 And also the responsibility and sort of the issues ASWs AMHPs were  
9 facing you know with the conveyancing. I just used to hear them  
10 moaning and groaning and you know and I mistook that for being this  
11 kind of self-important group but now I certainly can see the challenges  
12 you know we face when we're on duty. Umm despite years and years of  
13 forums and social care leads and national AMHP leads they never are  
14 resolved and you are kind of quite an isolated individual making the  
15 decision or dealing with the consequences of a decision and you are  
16 often on your own umm and it's quite challenging so I can now certainly  
17 appreciate that self-interest and that you know that self-advocacy as a  
18 group why it's so important.

During this reply, Paul changes from talking about 'them' to 'we' (line 12). Before he became a *member*, Paul 'mistook' the group as being 'self-important' (line 10-11). In contrast, now that he has become an AMHP he depicts himself as having realised the extent of the 'power' (line 6), 'responsibility' (line 8) and 'challenges' (line 11) associated with undertaking AMHP duty. In a powerful sentence containing a three part list and an extreme case formulation (Pomerantz 1986), these challenges are shown to be resistant to solution ['despite years and years of forums and social care leads and national AMHP leads they never are resolved']. Extreme case formulations 'are simply ways of referring to an object or event which invoke its maximal or minimal properties' (Hutchby and Wooffitt 1998 p.209). Paul also underlined the isolation of being on AMHP duty and the huge personal responsibility of being accountable for the decision (lines 14-16). This links with the article by Claire Gregor (2010) which was included in the literature review. Gregor (2010 p.432) argued that a significant amount of emotional labour is required in order to carry out this role with the AMHP unconsciously processing a 'wealth of powerful emotions and feelings'. Now that Paul has become an AMHP and carried out Mental Health Act assessments, he is able to understand the 'self-interest' and the 'self-advocacy' of the group (line 17). Towards the very end of the interview, I ask Paul what keeps him in the job:

1 Paul: I am in a position of authority and power and sometimes that can  
2 be used quite well. And I've always been one to say well if someone is  
3 unwell and they need hospital admission I will look at all the options and  
4 least restrictive but if that results in a good outcome for them in that  
5 they're safe, that's my baseline, that they're safe and other people are  
6 safe, then and I've enacted that then that's a good thing.

For Paul, then, using the Mental Health Act is a positive use of 'authority and power' as it results in keeping people 'safe', a word he emphasised by repeating three times. For Paul, the AMHP role has a positive impact ['if that results in a good outcome... then that's a good thing']. Thus, Paul does not designate the social control function of the AMHP role as dirty work.

The portrayal of AMHP work as being a high status role was also presented in the interview with an AMHP that I have called Frank. I have asked Frank about training to be an Approved Social Worker. Frank described the ASW training as 'wonderful', 'relevant', and 'high quality'. It interesting that Frank made the point that the training was distinctive in that the social workers were not 'sort of talked down to'. Thus, far from being trained in low status 'dirty work', the social workers were treated at the very least, as equals by the educators. Frank continued:

1 Frank: And I found it gave me more status within the team and among  
2 the medical, you know, people. That sort of dedicated role. I still really  
3 like AMHP work actually and probably for those reasons [laughs] I like to  
4 be taken seriously in what I'm doing and have some sort of status

5 Lisa: And do you feel that other than that role if it wasn't for that role  
6 that social workers wouldn't be seen in the same way?

7 Frank: It's yeah I expect so. Yeah it is an area of social work which is a  
8 crucial role which has to be done and because it's got that legal sort of  
9 tag with it I think it does give the profession a little bit of kudos. But I  
10 also worry that it's going to be taken away.

Like Paul, Frank described the 'status' that accompanies undertaking AMHP duty, repeating the word 'status' twice in his first reply. Frank depicted AMHP duty as providing social workers more 'kudos' (line 9) within the Community Mental Health

team, particularly with the medical staff (i.e. the doctors). For Frank, it is a 'crucial role' and the legal knowledge required in interpreting the Mental Health Act adds prestige (line 8-9). However, Frank is concerned that this 'kudos' is going to be taken away now that nurses, occupational therapists and psychologists can take on this duty. Frank went on to state that he is 'against' the introduction of the AMHP role. I ask for clarification:

1 Lisa: And what is it that – you say that you're against it – but what is it  
2 about it apart from the fact that it's our status?

3 Frank: Well that's part of it. That is part of it

4 Lisa: Having to share that, is that it?

5 Frank: Yes [laughs]

6 Lisa: [laughs]

For Frank, the introduction of the AMHP role is seen as negative as he does not want to lose or share the status associated with AMHP duty with other members of the CMHT. We both laugh at this somewhat childish notion of not wanting to share this duty and therefore status. Later in the interview, Frank explains why he sees AMHP work as having status.

1 Frank: I think it is something you know you are part of something.  
2 Something really quite important in society almost umm by being very  
3 involved in Mental Health Act assessments so I think that most people  
4 want to be part of it.

Undertaking Mental Health Act assessments is portrayed here as an important societal role. Frank's statement that he thinks that most social workers in the mental health team would want to be involved in Mental Health Act assessments is interesting as, arguably, it is not empowering for the service user to be detained in a psychiatric hospital against their will (although others might argue that it is more empowering than being at severe risk of committing suicide). Thus, for Frank, even the social control function of AMHP duty was not designated as 'dirty'. Indeed,

undertaking the AMHP training seems like a *rite of passage* whereby the social worker joins a higher status group. The distinction between non-AMHPs and AMHPs was also identified by other interviewees. Cath, for example, presented AMHP work as requiring a development of professional skills, including 'the way that you think':

- 1 Lisa: And did you think that it [AMHP work] changed your social work
- 2 role at all?
- 3 Cath: I think that you step up a gear, don't you, in the way that you think.

For Ed, rather than being dirty work, undertaking AMHP duty is portrayed as 'advanced social work':

- 1 Ed: The world of AMHP is very different isn't it?
- 2 Lisa: Yeah. Well tell me what you think the difference is?
- 3 Ed: It's just very it's kind of like an advanced social work isn't it?

My group membership is displayed in the exchange with Ed in my immediate reply confirming his assertion that the world of AMHP is very different ['Yeah']. This is one of the few occasions in the interviews that I was aware of Riessman's (1990 p.226) cautionary words that 'I wanted their, not my, understandings'. Consciously moving from being a member to being a researcher, I ask for clarification ['Well tell me what you think the difference is?'].

Tim, one of the AMHPs in the group interview, also made the connection between social work and AMHP work, describing being on AMHP duty as 'the last bastion of social work'.

- 1 Tim: someone said that AMHP stuff is the last bastion of social work and
- 2 perhaps maybe it is. Certainly in adult work it might be. It is because you
- 3 can't go by the content of your diary it's by a wing and a prayer and by
- 4 hoof really like you don't know where it takes you.

Here Tim's use of the word 'bastion' implies that there is a battle over the ability to undertake 'real' social work. Instead of being prescriptive and structured by appointments, AMHP work is by 'a wing and a prayer and by hoof'. This is an



interesting phrase which combines two expressions: 'coming in on a wing and a prayer' and 'being on the hoof'. The former expression means managing to succeed with very little and the latter means having to make decisions whilst in transition without having time to sit down and think about them in depth. Thus, through this phrase, AMHP work is depicted as challenging, unpredictable and requiring quick decisions about complex matters. Again, it is far from being designated as dirty work. Indeed, it is portrayed as 'real' social work.

In the interview with Andrew, I asked a direct question about the apparent dichotomy between social work values and the more controlling aspects of undertaking AMHP duty.

1 Lisa: Being an AMHP, how have you found that with your social work  
2 values in that you have talked about social justice and empowerment  
3 and things like that and obviously it's a more controlling, a more  
4 controlling

5 Andrew: Coercive

6 Lisa: Coercive side, especially with the community treatment orders and  
7 that. How have you found that fits in with your social work background?

8 Andrew: I think it fits in perfectly actually and that then kind of  
9 reinforces to me why social workers should be doing it umm because it's  
10 about reflecting on why you're doing it. I think it's about making sure  
11 that the decision that you're making are based on the right reasons umm  
12 and I feel I felt very guilty sectioning people and I think that's right, you  
13 know, and I've felt about the impact I've only been doing it a year and  
14 maybe in another ten years I might feel a bit more burnt out but I hope  
15 not, you know. [pause] But it draws on those reflective practices really,  
16 you know, are you making the right decision, are you approaching this in  
17 the right way, so it just requires more mental power really to umm think  
18 about the implication of what you're doing. It really, really does. The  
19 gravity of removing somebody's liberty liberty really weighs on me, it  
20 really does. I mean, my wife's a child protection social worker and  
21 obviously, she's a manager now, but she's removed children from their  
22 mothers at the hospital and it weighs heavily on you, and it does. So I  
23 think that. It fits perfectly with my social work values but it's got to be  
24 done. It's a very very important job and some people need to be in  
25 hospital I mean even if they don't want to be and you can see the good

26 of it at the other end because people come out of it better than when  
27 they went in. There's damage done, there's always damage done but  
28 ummm, yeah [pause]

It is interesting here that I struggle to find the right word and Andrew supplies it. This demonstrates how the interviewee can also contribute to a question and does not play a purely passive role. By repeating the word 'coercive' I am acknowledging that this is an appropriate word to describe the point I am trying to make, even if it was not a word that I would use (line 1-6). Rather than being the dichotomy I have discussed above, for Andrew there is a perfect fit ['it fits in perfectly actually'] between social work and AMHP duty as being on AMHP duty requires 'reflectiveness' which is strongly associated with social work (see the section below on supervision for further discussion of this). However, Andrew then goes on to discuss the emotional impact of detaining someone. Andrew stated that feels 'very guilty' (line 12) and explained that 'the gravity of removing somebody's liberty really weighs on me, it really does' (line 18-19). Here the use of the phrase 'really weighs on me' evokes an image of an intense, almost physical, impact as does repeating the word 'liberty'. Andrew makes a link between detaining someone under the Mental Health Act and removing a child as a child protection social worker (line 20-22). Arguably, these are two of the most controlling aspects of social work practice. Repeating the phrase 'it weighs heavily on you' further emphasises the intensity of this emotional impact (line 22).

Again, AMHP duty is described as involving increased skills ['it just requires more mental power really to umm think about the implication of what you're doing. It really, really does]. Andrew then reiterates that AMHP duty 'fits perfectly with my social work values...' (line 23). What is interesting here is that this sentence is then concluded with '...but it's got to be done' (line 23). The use of 'but' seems incongruent here. This conjunctive is used when two individual components on either side of the 'but' in a sentence are contradictory. It would make more sense if Andrew had said AMHP duty does not fit with my social work values but it's [a role that's] got to be done. While it may just be a slip of the tongue, it may also suggest

that Andrew is aware of some disjuncture here. The latter interpretation appears to correspond with an ambiguity in the final part of Andrew's reply to this question. Andrew begins with a positive view of the impact of detention on service users ['people come out of it better than when they went in'] but ends by acknowledging that it also has a negative impact ['There's damage done, there's always damage done']. The reply then seems to peter out: 'but ummm, yeah [pause]' which again, may be as a result of the implicit disjuncture (line 27). Thus, in his story, Andrew depicted some elements of AMHP work as 'dirty'.

Later in the interview, I return to this theme of the impact of compulsory detention. Andrew has described the impact on the relationship with a service user after the use of compulsory detention. I note:

- 1        Lisa: So that you, you can see that there is an impact there then?
- 2        Andrew: Yeah but it's definitely on a case by case basis really. Some  
3        people are so unwell that they don't recognise it. But when I've spoken  
4        to other AMHPs what they've said is that they're had a mixture of  
5        experiences where people have thanked them in the long run because  
6        they were engaged in such risky behaviour that umm when they're come  
7        out the other side and regained capacity and well enough to reflect on  
8        what had happened, they've kind of said, "*oh my God, what was I*  
9        *doing*", you know, and I've spoken to people who have said it's actually  
10       reinforced the relationship and it's that thing about Advance Directives  
11       too, once people have put on paper, you know, "*if you're going to*  
12       *section me, can you do it like this instead, can you do this instead*". So  
13       that's a really good positive way of doing it, I think. Participation makes  
14       people feel less disempowered, more in control. It's a recognition that  
15       they're probably going to get unwell again because that's unfortunately  
16       the nature of their illness. So they're taking a degree of control back on it  
17       and that's working in partnership with the person, so I would hope that  
18       that kind of thing might happen to me in the future.

Andrew begins by acknowledging that there can be an impact on relationships with service users but goes on to present the view that this does not happen in all cases; a statement which is 'authorised' by others (Smith 1978) ['I've spoken to other AMHPs what they've said']. Andrew uses active voicing (line 8 and line 11-12) to

describe the 'good positive way of doing it' (line 13), where service users are presented as being grateful and where the relationship has 'actually been reinforced' (line 10). However, prefacing the claim with the word 'actually' hints at a possible disjuncture from what might be expected. Indeed, this might be seen as a form of what Hughes (1971 p.340) called 'dignifying rationalizations'; namely, an attempt to present AMHP work as valued by service users. Andrew ends by using a number of words and phrases which align with social work values: 'participation' (line 13); 'less disempowered and in control' (line 14); and 'working in partnership with the person' (line 17). It is arguable that many people including service users would not equate these terms with the social control function of compulsory detention. This perspective that the AMHP is doing something alongside *with* the service user is interesting. Here AMHP work is presented as not the *doing to* identified by Hughes (1971 p.305) and Emerson and Pollner (1975 p.236), or even as the *doing for*. This demonstrates how social work language has changed from the therapeutic *for* to *working in partnership*. Once again, it is clear that AMHP duty is not being designated as dirty.

I ask Ben the same question.

- 1 Lisa: How do you find the fact that you are taking away somebody's  
2 liberty in the role?
- 3 Ben: I think to some degree going back to the political discussion we had  
4 at the start I came in to the idea that you would be an agent of the state  
5 [laughs] and part and parcel of that was care and control. So hopefully as  
6 an individual I came into it and I think where I worked before and when I  
7 worked here there was an expectation that you would do the training  
8 you would work as a backup person for an AMHP for a number of years  
9 so I think that you have that your eyes are open really before you  
10 actually do the role. But it's difficult, isn't it, the role? It's certainly not  
11 what you come in for really. I think a bigger frustration really is not being  
12 able to use it when you see that people very unwell who are potentially  
13 very vulnerable and you're having to walk away. That's more of a  
14 frustration really than the actual control
- 15 Lisa: It just seems cruel, doesn't it?

16 Ben: Yes. And it's you're the one there with the family and sort of umm  
17 [pause]. I had a discussion with the bed manager who has been very  
18 angry recently as a family member had got hold of his number and was  
19 giving him a hard time about not having a bed and we need to sort this  
20 person out. This happens every day for us. We are the people at the  
21 house not just on the phone. We're the one who's having to walk away  
22 and explain the reasons why. I'm not sure if I have brushed over the  
23 power issues but I think [pause] I'd hope that social workers come in to it  
24 with their eyes open. I mean part of the competencies on the DipSW as it  
25 used to be was care and control and demonstrating that you could work  
26 within them. Umm I think probably compared to childcare we have a lot  
27 more autonomy within mental health to try and work in less restrictive  
28 ways. I see colleagues who work in childcare and everything seems much  
29 more procedurised, every decision that they want to make they have to  
30 speak to their seniors or the lawyers. Similarly in adult services generally  
31 things everything care management seems to be very procedurised in  
32 assessment processes and I think we have more autonomy within mental  
33 health really.

Ben presents himself as always being aware that a social worker is 'an agent of the state' (line 4). This refers to a key debate in social work: are social workers agents of social change or are they agents of the state? The definition of social work produced by the International Federation of Social Workers (2000), which was reproduced in full earlier, positions the social work profession as promoting social change, empowerment and liberation, with principles of human rights and social justice as fundamental to social work. This definition presents a very positive view of social work with a focus on empowerment, social change and social justice. However, this definition does not acknowledge that social work has a controlling and surveillance role which is maintained alongside the focus on empowerment and social justice. There is a tension and ambiguity at the heart of social work practice (Parton and Kirk 2010 p.26) between empowerment and control. Ben recognises this tension that AMHP duty involves both 'care and control' (line 5) and that acting as 'backup' [i.e. an assistant] to the AMHP on duty means that 'your eyes are open really before you actually do the role' (line 9). Ben then continues by acknowledging that there is a dichotomy: 'But it's difficult, isn't it, the role? It's certainly not what you come in for really' (line 10-11).

Ben continues by distinguishing what is difficult: it is the lack of beds that is more frustrating than the social control element of the role (line 11-14). This is an example of the use of the documentary method of interpretation. Recall that Garfinkel (1967 p.35) explained that many matters that the members of an interaction understood 'were understood on the basis not only of what was actually said but what was left unspoken'. Ben does not have to clarify what he means when he says: 'not being able to use it ... and you're having to walk away' (line 12-13). Here Ben is referring to the lack of psychiatric beds. An AMHP may assess someone under the Mental Health Act and decide that the person does need to be admitted to hospital but a bed in a psychiatric ward is not available. Thus, the person cannot be admitted and the AMHP is forced to try and find alternatives which may leave the person in a situation of risk. This has been an on-going problem and was something I experienced from the time of qualifying as an ASW in 1997. This was mentioned by almost all of the AMHPs as one of the most difficult issues of undertaking assessments under the Mental Health Act. I acknowledge the seriousness of the problem in my reply by using a very emotive word ['cruel']. I have experienced this frustration during my work as a social worker. Again, this demonstrates the emotional labour inherent in AMHP work.

Ben illustrates the degree of the emotional impact on AMHPs by going on to tell a narrative about the bed manager ['We are the people at the house not just on the phone. We're the one who's having to walk away and explain the reasons why']. Once again, this story exemplifies the emotional labour of being an AMHP on duty. Thus, through his story about the bed manager, Ben is designating this aspect of AMHP duty as 'dirty'. Ben then returns to my original question and again uses the metaphor of people becoming social workers with 'their eyes open' (line 24). He points to the emphasis on being able to work within care and control as part of social work training (line 24-26). Finally, Ben presents mental health social work as more autonomous, less restrictive and less procedurised compared with social workers working with children and in services for adults (line 26-33). This links with

Tim's description of AMHP work as the 'last bastion of social work' discussed earlier. Again, Tim and Ben are describing what they see as 'real' or 'proper' social work.

Grace also discussed the ambiguity in being an AMHP on duty.

1 Grace: [pause] I think you go through or I would hope you go through  
2 people go through that [pause] debate you have in your head about  
3 somebody being detained against their will in an environment with a  
4 group of strangers they don't know. I went through a lot of that you  
5 know what that meant I suppose. It's not just the other service users it's  
6 staff. You know going up on the wards and seeing that in its reality was  
7 difficult but so was the thought of going home and leaving that person.  
8 So I could always critique each way quite well.

9 Lisa: Is that a role now that you enjoy doing, that AMHP role?

10 Grace: I I ok when I do the debate of what do I why am I passionate  
11 about AMHP work is because I think that there needs to be somebody  
12 there who is really making a clear really rounded decision of what is in  
13 the person's best interests. I think it needs to be done. When somebody  
14 is at their weakest it needs to be somebody at their strongest who's  
15 going to challenge the doctors, who's going to say "*no that's not right*",  
16 who's going to be, who's going to act for you when you can't. And I think  
17 I'm absolutely the best personality type for that. Do I like what's  
18 happening now? No. You can't get a bed, the ambulance crews don't  
19 want to use the Mental Capacity Act, you might not get the police. I do  
20 out of hours work so I get the whole 360 view of everything you know  
21 sitting somebody in the leather chair down at A and E with a sandwich  
22 because that's all you've got doesn't feel nice. Umm being shouted at by  
23 A and E staff because there's no beds. That's made it not so nice. Umm  
24 yeah the sort of systemic pressure of trying to coordinate is not very nice  
25 at all.

Here Grace makes reference to the ambiguities of detention, namely having to decide whether to detain someone in the negative environment of the psychiatric ward (line 3-6) or to leave the person in an unsafe situation at home (line 7). Grace describes herself as the 'best personality type' (line 7) to undertake AMHP duty because she is strong, assertive and able to challenge doctors (line 14-16). Grace continued by outlining the difficult aspects of being an AMHP: the lack of beds (line 18); the lack of knowledge about the Mental Capacity Act by ambulance crews (line

19); the unavailability of the police (line 19); being 'shouted at' by Accident and Emergency staff because there are no beds to transfer the service user to (line 22-23); and the lack of facilities in the Accident and Emergency department for a service user (line 21-22). These are summarised in the coda to her reply as the 'systemic pressure of trying to coordinate' (line 24). It is the AMHP's duty to co-ordinate the assessment under the Mental Health Act 1983. Therefore, for Grace, it is these systemic pressures that make being on AMHP duty difficult and not the act of detention. This is the 'dirty work'.

The final example that the AMHPs did not see the social control function of enforced detention as dirty work is from the interview with Eva.

- 1 Lisa: And how did you find detaining somebody, taking away someone's  
2 liberty, the first few times you did it, or even before, the thought of it?
- 3 Eva: Do you know, I don't, I know some people get really upset about  
4 doing it [pause] I I get very upset about people's lives but I never think  
5 well I if you think you're doing the wrong thing in detaining someone  
6 then you shouldn't be detaining them. It's you're going in and there  
7 should be a dreadful situation and the outcome of putting someone into  
8 hospital means it's the best thing to do for the person. If you don't do  
9 that then their life's going to get worse than they already are. I never I  
10 never grapple with the act of detention itself. I mean sometimes I think  
11 I'm going to detain you and you're going to this horrible hospital, you're  
12 going to hate it and it's going to be awful but I hope that you get some  
13 sleep. I hope that you get, you know, you get some time away from the  
14 crisis that's caused this. You hope for the best and I for lots of people it's  
15 [pause] if you talk to them about being detained and obviously they're  
16 not very happy about it but they don't hate it as much as you think they  
17 do. There're a lot of people that develop an understanding. You know, I  
18 was talking to one of my patients the other day and she was saying "*I*  
19 *lost my mind. I didn't know what I was doing*" and if I said "*do you wish I*  
20 *hadn't detained you?*" she wouldn't say "*no*", she would wish she hadn't  
21 got ill in the first place but would say "*that's what they had to do*  
22 *otherwise I would have killed myself*". So yeah I don't I don't mind it at all  
23 really

Eva explained that 'I never grapple with the act of detention itself' (line 9-10). For her, it is the person's situation that is upsetting, not the act of detention (line 4). Eva



argued that detention is the 'best thing' (line 8) if a service user is in a 'dreadful situation' (line 7) and if 'their life's going to get worse' (line 9). Like Grace, Eva acknowledges that 'you're going to this horrible hospital, you're going to hate it and it's going to be awful' (line 11-12). However, at the same time, the admission means that the person can 'get some sleep' (line 13) and can 'get some time away from the crisis that's caused this' (line 13-14). This elucidates the ambiguity and contradiction inherent in AMHP work; although compulsory detention is incredibly difficult and undoubtedly has a negative impact on people's lives, the alternative might be that person coming to harm.

Eva clarified this perspective by introducing a story about a service user (line 17). What is interesting here is that Eva was not reporting a conversation she had previously had with this service user; instead she is voicing what the service user *would have said had she been asked* ['if I said do you wish I hadn't detained you, she wouldn't say no, she would wish she hadn't got ill in the first place but would say...']. This is a very good example of why Wooffitt (1992) introduced the term 'active voicing' to replace the term 'reported speech'. Indeed, Eva was describing an entirely fictional exchange as denoted by the phrases 'if I said', 'she wouldn't say' and 'would say'. In fact the only part of the conversation which is presented as *reported* speech was the first utterance attributed to the service user [“*I lost my mind. I didn't know what I was doing*”]. Here the use of active voicing can be seen as a way of providing evidence for Eva's claim that service users 'develop an understanding' that detention can be necessary (line 17). Buttny (1997) showed how quoting another's words can convey an air of 'objectivity' about what happened, strengthening the claim. Here the story about the service user can be seen as a 'dignifying rationalization' (Hughes 1971 p.340). The coda to the story reiterates that in terms of undertaking compulsory detention, 'I don't mind it at all really' (line 22).

To conclude, then, far from being designated by the social workers as 'dirty' or 'shit' work, being on AMHP duty is seen as prestigious, requiring advanced skills, and the ability to manage very complex situations. The AMHPs did not seem to view the

controlling side of AMHP work as conflicting with their social work values of empowerment and social justice. Of course, to undertake AMHP duty would mean that, at the very least, a social worker would have to be comfortable with the role. Arguably, social workers who see AMHP duty as incompatible with social work values would not choose to train or work as an AMHP. However, it is clear that AMHP duty holds an inherent ambiguity. Although the AMHPs do not see the act of detention as dirty work that is not to say that they do not find it difficult or uncomfortable. The work clearly contains tensions; for example, although the AMHP believes that the person needs to be in hospital, they are also aware that the wards are often bleak and sometimes dangerous places to be. The lack of beds, the complexities of co-ordination, and the emotional labour of engaging with people experiencing mental distress means that being an AMHP on duty is emotionally difficult and mentally draining. It is therefore interesting that the AMHPs deemed this work as 'real' or 'proper' social work. Specifically, AMHP work is 'real' social work because it encompasses being autonomous; managing complex situations in the least restrictive manner; and being assertive on behalf of service users. In my study, AMHP duty is not seen as dirty as the AMHPs are in control of their work and are autonomous. This aligns with Brown's (1989) findings that it was the threats to the control and autonomy of the team that resulted in work being designated as dirty. However, through their storytelling, the social workers clearly delineated the aspects of AMHP work that they did designate as dirty, specifically the lack of beds, the complexities of co-ordination, and the emotional labour which is an inherent part of the work. This finding aligns with Hughes' (1951) argument that every occupation contains a bundle of activities, some of which are the dirty work of that group.

Before moving on, it is important to acknowledge that my fieldwork approach differs from that taken by Emerson and Pollner (1975) and Brown (1989) in that they both took an ethnographic approach. Emerson and Pollner (1975) clearly stated that dirty work designations are more likely to be articulated where there are observers

present when the staff were actually undertaking the work. I did not observe the AMHPs undertaking the Mental Health Act assessments and it may be that had I done so, they may have designated the work as dirty. However, having observed numerous ASWs on duty undertaking Mental Health Act assessments as a social work student; acting as a 'back up' [assistant to the ASW on duty]; and as an ASW trainee this has not been my experience. Of course, this may be because I was a 'marginal native' or social work member at the time rather than a researcher like Emerson and Pollner. However, Brown described himself as a trusted member of the team, and yet some work, the external nonpsychiatric referrals, was still designated as dirty.

The discussion will now move to explore other aspects of being an Approved Mental Health Professional. The discussion will thus shift from the narrow focus on AMHP *duty* to the wider role of being an Approved Mental Health Professional seconded to a Health Trust.

### **4.3 Making social work visible**

#### **4.3.1 Being seconded to a Health Trust**

The focus of this section of the chapter is to explore the implications of being a social worker seconded to a Mental Health Trust. The social workers interviewed for this research project were all seconded to Mental Health Trusts, apart from the members of the group interview who remained separate from the Community Mental Health team (CMHT). The first part of this section is concerned with the isolation of being a social worker in a Health Trust. Leading on from this, there will be a discussion about supervision arrangements within the Trust. The final part of the section will discuss the links that the social workers maintain with their Local Authority employers.

The notion of 'visibility' is a reference to the work of Andrew Pithouse. Pithouse (1984; 1998) suggested that social work was an 'invisible trade' which was only made visible through talk with social work colleagues and in supervision with social work managers. For Pithouse (1998 p.178) social work was accomplished in the setting; in other words, the occupational reality was continually maintained in the conversational work of competent members. The children and families social workers in Pithouse's study were based in the Local Authority. Thus, they were situated with social work colleagues and social work managers which meant there was a 'shared frame of reference' (Pithouse 1998 p.165). In contrast, the social workers in my project are separated from other social workers and situated with health professionals and thus this 'shared frame of reference' does not exist. This notion of 'visibility' also connects with Garfinkel's focus on the 'witnessable', the 'observable-and-reportable', what he called 'account-able'. The central recommendation of ethnomethodological studies is that:

...the activities where members produce and manage settings of organized everyday affairs are identical with members' procedures for making those settings "account-able"... i.e. available to members as situated practices. (Garfinkel 1967 p.1)

In other words, it is through the ongoing accomplishment of social work in the interaction with other social workers that social workers make the familiar, commonplace activities of social work recognisable *as* familiar, commonplace activities of social work (Garfinkel 1967 p.9). If social workers are not able to make social work 'account-able' in interaction, then social work is not 'visibly-rational-and-reportable-for-all-practical-purposes' (Garfinkel 1967 p.vii). Hence, social work will not be made visible. This notion will now be explored in relation to my interviews.

### **4.3.2 Being isolated from other social workers**

The majority of the social workers interviewed for this research project only had one or two social work colleagues in the Community Mental Health team. Instead, their

colleagues were health professionals such as nurses, doctors, psychologists and occupational therapists. Even if there were other social workers in the team, this did not automatically mean that the other social worker was a 'bona-fide' and 'competent' member. For example, there was only one other social worker in the team where Nell was based. Nell described her feelings of isolation:

- 1 Nell: Yeah and in this team because I'm the only well there is another
- 2 social worker but she's employed by [the health trust] and so her
- 3 training and her she's not an AMHP you know she's very much a nurse
- 4 with a social work body [laughs]

Nell distinguished herself from the other social worker in the team. Whereas Nell was employed by the Local Authority and seconded to the Trust, the other social worker was employed directly by the Health Trust and also was not qualified as an AMHP. Nell depicts this social worker as not a 'real' social worker but as a 'nurse with a social work body'. Although this is a humorous phrase and Nell laughs, it is not a laughable but is 'troubles talk' (Jefferson 1984) and I do not respond by laughing. Thus Nell felt isolated as a social worker within the Health Trust. I asked her about this:

- 1 Lisa: How do you feel when you've been so isolated?
- 2 Nell: Umm [long pause] I mean sometimes it would have been nice to
- 3 have colleagues in the team who were [pause] field as me [pause] and
- 4 things when social work things do pop up all the eyes in the room do
- 5 look towards me [laughs]. We had somebody a patient who had a new
- 6 baby. I think the baby was about two weeks old and she'd gone home
- 7 and she wasn't managing at all and so we had to do a referral to children
- 8 and families. Bloody great form. The name and date of birth you have to
- 9 write in about sixteen times it's just so tedious. And everyone looked at
- 10 me and I was like "*why do I have to fill it in? I didn't even meet the*
- 11 *patient! People that met the patient I don't mind sitting with them while*
- 12 *they go through the form*" I don't mind sitting with colleagues going
- 13 through forms. You get used to forms don't you as a social worker? But
- 14 suddenly it was like "*leave it for Nell to do*". I come into work and it's like
- 15 "*oh we need a referral to the children and families team - here you are*"
- 16 [laughs] and I'm like "*why's it my job?*" "*You're a social worker*" "*what*
- 17 *has that got to do with filling in a referral?*" Which is now a day late.

18 Lisa: And you've not even met the person?

19 Nell: I've not even met the person. Not good at all. So yeah at times like  
20 that it would be nice to have other colleagues to share issues like that  
21 with but I think [pause] maybe if there were other social workers we  
22 would get pushed into that role all the time while I can strongly argue  
23 *"there's only one of me. I can't be doing all the referrals for AMHPs, all*  
24 *the referrals for children and families, all the benefit forms, otherwise I'd*  
25 *never do anything else"* [laughs] and say to people *"no, you need to learn*  
26 *how to do these as well. I've had to learn nursing bits, regardless of*  
27 *whether I wanted to or not, I've had to as part of this job so equally you*  
28 *have to learn social work-y social work-y bits as well"*. So [pause] I  
29 haven't felt too – I suppose I'm used to being a bit of a maverick I think.  
30 Is that the word?

31 Lisa: Yes maverick.

Here Nell is talking about the pressures of being the only 'real' social worker in the team. It means that she has to deal with all the tasks that are commonly associated with 'social work' by the other members of the team ['when social work things do pop up all the eyes in the room do look towards me']. Nell illustrated this claim with a story about a service user with a new baby. It is notable that the service user is referred to as a 'patient' throughout. It would be very surprising to hear this term used by social workers in a Local Authority setting. This may be an example of the dominance of medical terminology in a Health Trust. In the story, even though other members of the team had met the service user and Nell had not, it was seen as her task to complete the form due to it being a referral to Children's Social Services. Nell uses active voicing to great effect, moving from the past to the present through the use of asides ['I'm like *"why's it my job?" "You're a social worker" "what has that got to do with filling in a referral?"* Which is now a day late.']. Although the story is humorous, and Nell laughs during the telling (line 16), it is 'troubles-talk'. Thus, I did not laugh but instead acknowledged the ridiculousness of the situation by reiterating her point that she had not even met the service user (line 18).

Nell continued by making the point that as the only (real) social worker she does not have the time to undertake all the 'social work' tasks. Again using active voicing,

these social work tasks are identified as: 'referrals for AMHPs'; 'referrals for children and families'; and completing 'all the benefit forms' (line 23-24). Nell pointed out that she has to do 'nursing bits' (line 26) as part of the job, so argued that the nurses should learn to do these 'social work-y bits' (line 28). Nell concluded her reply by describing herself as a 'maverick'. Here a 'real' social worker is depicted as being a non-conformist and individualist within the mental health team. Next, I asked Nell if she thought that she brought anything distinctive as the only (real) social worker in the Community Mental Health team.

1 Lisa: Do you feel you bring something different to the team, having you  
2 in it?

3 Nell: Oh yeah I think so. I think it would be a loss not to have social work  
4 qualified people in a team because you're going in to people's homes all  
5 the time and you see and pick up stuff that nurses don't seem to ummm  
6 [pause] they see it but they don't seem to recognise the umm possible  
7 effects or repercussions or, you know, someone's been given a flat and it  
8 wasn't decorated when they were given it and they didn't get their grant  
9 to decorate it. I mean sometimes it's a splash of paint could make a huge  
10 difference. And the client's saying "*I don't want to go home. I can't stand*  
11 *this flat. I don't want to be here*" and you know no one thinks to ask why.  
12 Or even if you can see why and you're thinking "*god this place is falling*  
13 *to pieces*" they don't think to ring housing and say "*oh actually when this*  
14 *person was allocated a flat they should a grant just to tart it up a bit or*  
15 *just to get the basic equipment*". Just to speak up for people a bit.  
16 [pause] You feel if you weren't there it wouldn't happen which is a bit  
17 sad really. You go round there and shove some tablets at somebody  
18 umm "*how's your mood? Have you had any self-harm thoughts today?*"  
19 you know, and then you go off again and go on to the next person and  
20 the fact that they're living in a cold flat because the central heating isn't  
21 working, the boiler broke down two years ago and has never been fixed  
22 you know, these things just just sail over people's heads just. I think how  
23 can you be comfortable in your own home or how can you even start to  
24 get happy or get out of depression if you've got no heating, no hot  
25 water, so how you going to clean yourself? And they say "*oh they're*  
26 *dirty*". I think of course they're dirty. They're freezing cold. I wouldn't  
27 take my clothes off and have a wash if I was cold [laughs] and nowhere  
28 to dry their clothes if they did wash it [pause] And the effect on  
29 someone's mental state or their mental health, their mood, their  
30 depression, it's not [pause] it's like they don't tie up the two things. It's  
31 very frustrating.

It is notable that in this reply Nell referred to the person as a 'client' (line 10) rather than using the term 'patient' as she did in the earlier story. The difference may be explained by the nature of the story. In this story, Nell is contrasting the differing perspectives of nurses and social workers, with only social workers being able to see the effects of the social circumstances that people are living in ['you see and pick up stuff that nurses don't seem to ummm [pause] they see it but they don't seem to recognise the umm possible effects or repercussions']. Nell portrays social workers as having the ability to see a situation in its entirety in contrast to the nurses where 'these things just just sail over people's heads' (line 22). In the story, the social worker was able to make the connection between inadequate housing and the impact on mental health; in contrast the nurse cannot 'tie up the two things' (line 30). Instead, the sole focus of the nurse in the story is on medication and symptoms ['You go round there and shove some tablets at somebody umm "*how's your mood? Have you had any self-harm thoughts today?*"']. Thus, the social worker sees the whole 'person', hence the use of 'client', with the nurse only seeing the 'patient'. Through this story, Nell is claiming that only social workers are able to achieve an accurate and complete understanding of the situation. In contrast, nurses are presented as having a narrow focus solely on medication. Thus, Nell is contrasting the social perspective with the medical model. The coda to her reply provided a summary: it is 'very frustrating' being the only (real) social worker in a team of health professionals.

Later in the interview I asked Nell if she had a social work manager. She replied that both of the two managers in the team are nurses.

- 1 Nell: Now I have no social work manager at all which [pause] yeah they
- 2 haven't got a clue really. Supervision is a joke.
- 3 Lisa: Do you have supervision?
- 4 Nell: It doesn't happen.



Thus, not only was Nell the only social worker seconded to the Health Trust, she did not have a social work manager. It was clear that she was very isolated as a social worker in this team. Nell presented the nurse managers as not having 'a clue' about social work and supervision as a 'joke' and 'doesn't happen'. Her reply can be interpreted in two ways: supervision might not have taken place or something that might be called 'supervision' occurred but it is not 'real' supervision. The next section will explore the subject of social work supervision in more depth.

### **4.3.3 Making social work visible: social work supervision**

In his report of the Inquiry into the death of Victoria Climbié, Lord Laming (2003 p.12) identified supervision as 'the cornerstone of good social work practice'. The British Association of Social Workers supports the following definition of social work supervision:

Supervision must enable and support workers to build effective professional relationships, develop good practice, and exercise both professional judgement and discretion in decision-making. For supervision to be effective it needs to combine a performance management approach with a dynamic, empowering and enabling supervisory relationship. (Skills for Care 2007)

It is through social work supervision that social workers receive emotional support and reflect upon their practice and is an important alternative to the managerialist approach (Carpenter et al. 2012) where supervision is focused on efficiency, accountability and worker performance (Noble and Irwin 2009). This section will explore supervision in more depth by analysing talk-about-supervision from three of the interviews. Once again, the work of Pithouse will be used as a reference point for my findings. Pithouse (1984) concluded that supervision is crucial in social work as it is where social work is made visible:

It is here in the supervisory encounter that work and worker are 'seen' in mundane occupational talk steeped in the processes of social

organisation. It is here that for all intents and purposes work is made visible and accomplished as a routine orderly event. (Pithouse 1984 p.15)

Thus, social work is accomplished in supervision through mundane occupational talk. It is through 'telling the case' (Pithouse 1984 p.371) in supervision that the social worker accomplishes his or her social work identity as well as the identity of the service user. Work can only be made 'visible' through shared occupational talk where the social worker successfully accomplishes doing being a social worker. It is in supervision, then, that the social worker is recognised as being a 'cultural colleague' (Garfinkel 1967 p.11). Here invisible practice is evaluated in a 'simultaneous exhibition of both worker and work' (Pithouse 1998 p.10). The social workers in Pithouse's study were all supervised by social work managers. Today, the majority of children and family social workers remain based in Local Authorities and still have supervision with managers from a social work background. However, in mental health services, most social workers are based in Mental Health Trusts where they may or may not have a manager who is from a social work background. We saw how Nell's managers were both from a nursing background and this means that she is supposed to receive supervision from one of these nurses. However, Nell ambiguously described supervision as non-existent and as a 'joke'. This section will now examine talk-about-supervision from two other interviews.

The first extract about supervision is from an interview with an AMHP I have called Rose. Rose has just explained that she has worked in two mental health teams before her present position. I ask:

1 Lisa: And what about in the teams, did you have a social work manager  
2 in both?

3 Rose: No in [name] I had a nurse as a supervisor and I found that difficult  
4 actually. I found it very prescriptive umm I don't know if it's to do with  
5 the profession or the personality of the supervisor but I found it was very  
6 much like doing a shopping list I thought. Not very reflective or and the  
7 umm manager here is an AMHP who's my supervisor so it's very  
8 different. Having a nurse I think it I don't know I'm sure they do like anti-  
9 oppressive practice background or the equivalent to that but it doesn't

10        come across as much in the way they approach supervision. I found that  
11        quite difficult. It's a very different sort of background I think so.

In this extract, Rose contrasted being supervised by a nurse and a social worker. She reiterated how 'difficult' (line 3 and line 11) and 'different' it was to have supervision with a nurse compared to a social worker (line 8 and 11). Supervision with the nurse is presented as 'prescriptive...very much like doing a shopping list' (line 6). In contrast, supervision with a social worker is 'reflective' (line 6). At first, Rose stated that this approach could stem from the personality of the individual nurse rather than nursing as a profession (line 5). However, she then widened this to nursing as whole by the using the collective 'they' ['I'm sure they do like anti-oppressive practice background or the equivalent to that but it doesn't come across as much in the way they approach supervision']. Thus, the difference in the approach to supervision is presented as originating from the differing training and educational background of nurses and social workers. Here Rose is presenting anti-oppressive practice as strongly associated with social work. In all of the interviews, there was a focus on anti-oppressive practice and social justice as a distinctive feature of social work and this was used to distinguish social work from the other professions within a CMHT. In contrast, even though the nurses may have an anti-oppressive practice background (Rose implicitly acknowledges that she cannot claim to know this for certain) Rose stated that it does not 'come across as much in the way they approach supervision' (line 10).

My next question revealed my shared background expectancies about social work supervision.

1        Lisa: And what about when you were in that team with the nurse  
2        manager – did you have social work colleagues?

3        Rose: Yes

4        Lisa: And did that help?

5       Rose: Yes definitely. Especially around the AMHP work, you know, you  
6       could get ideas from them and advice so yeah. I've always asked  
7       colleagues for advice or help as well, especially when I was new to the  
8       job. But umm yeah I think with nursing it's different. It's very sort of  
9       more authoritarian I think and "*this is what I'm the manager and this is*  
10      *what you need to do*".

Here my questions display my awareness that supervision can also come from social work peers. Rose begins by affirming my assumption and extending it to include AMHP work (line 5). Her 'you know' (line 5) reflects our shared background expectancies that peer supervision is particularly important when working on AMHP duty when specialist technical legal knowledge about the Mental Health Act is needed. At this point in the interview (line 8), Rose does not continue to answer my question about peer support but returns to her original point about nursing as 'different': the phrase 'But umm yeah' marks this as a 'dispreferred response'. Anita Pomerantz (1984) discussed some features of 'preferred' and 'dispreferred' turn shapes when agreeing and disagreeing with assessments. Pomerantz (1984 p.77) concluded that, in general, 'dispreferred-action turn organization serves as a resource to avoid or reduce the occurrences of overtly stated instances of an action'. The use of delay devices (such as silences, hesitating prefaces, or requests for clarification) prior to disagreements are one way in which a speaker may attempt to lessen an overt disagreement. Finally, in another contrast structure, Rose presents supervision with a nurse as 'very sort of more authoritarian' in comparison with social work supervision with active voicing adding to the weight and impact of her assertion (line 9-10).

After establishing that Rose had a social work manager in her first job and the nurse manager in her second job, I continued:

1       Lisa: But it's interesting that you could notice the difference – and was it  
2       the reflectiveness that we like to do in social work that was missing?

3       Rose: Yes definitely. Oh yeah. It was very much "*what's happening with*  
4       *this?*" very pragmatic, looking at the practical rather than anything about  
5       what's going on or what's the dynamics of the situation or anything.

My question, 'was it the reflectiveness that we like to do in social work that was missing?', displays my shared social work identity in two ways: the use of 'we', and my tacit knowledge that social work supervision is implicitly associated with 'reflectiveness'. Rose's emphatic affirmation (line 3) works to reinforce our shared membership. Once more, supervision by a nurse is contrasted with social work supervision. Here Rose presented supervision with a nurse as 'very pragmatic' and 'looking at the practical' (line 4) compared to social work supervision which is 'about what's going on' and 'the dynamics of the situation' (line 5). Again, active voicing works to support the contrast structure. The interview continues with my asking:

- 1 Lisa: And did you find that frustrating?
- 2 Rose: Yes I did. Sometimes I'd think I'm fed up of talking: "*I may as well*
- 3 *just fax this over to you*" you know, write one sentence about everyone
- 4 [both laugh] "*he's going to a daycentre she's going to a benefits*
- 5 *assessment*" yeah.

Here, too, my question that this type of 'pragmatic' and 'practical' supervision would be 'frustrating' for a social worker displays my shared background expectancies. Rose's response uses active voicing and humour to describe how supervision with a nurse is so prescriptive that it could be done by fax. Thus, unlike the social workers in Pithouse's (1984) study, Rose is not able to make social work visible in supervision with the nurse. The nurse does not share the same occupational rhetoric and so Rose cannot accomplish a social work identity through their mundane institutional talk. In direct contrast, however, within the interview interaction we do share the same occupational rhetoric. The shared laughter (line 4) contributes to our ongoing accomplishment of doing being social workers. The interview continues:

- 1 Lisa: So did you feel during that time that you developed professionally?
- 2 Rose: Umm [pause] I think because I was also doing my AMHP training at
- 3 that time so that kind of counteracted it a bit because I had a good
- 4 AMHP supervisor who was very much about reflection and very good at
- 5 thinking things through. So I suppose that helped. But had I not had that
- 6 then yeah I think it may have stopped me yeah.

Once again, this question displays my competence in social work in the way that 'supervision' is presented as associated with 'professional development'. Here Rose's 'umm' and delay in answering (line 2) may be because the 'preferred' response to affirm my taken for granted assumption would be 'no' (that not having social work supervision should lead to a lack of professional development). However, Rose stated that because she was undertaking AMHP training, this 'counteracted' the supervision with a nurse (line 3). In contrast with the nurse manager, the (social work) AMHP supervisor was 'very much about reflection and very good about thinking things through' (line 4). Therefore, despite having a nurse manager, Rose was able to develop professionally because she had a social work AMHP supervisor. Rose's last sentence repairs the 'dispreferred' response at the beginning of her answer ['But had I not...']. Through her narrative, Rose used a series of stories about being supervised by a nurse. These stories defined social work supervision through the use of a contrast structure with supervision by a nurse. For Rose, social work supervision is about reflectiveness, anti-oppressive practice, and understanding the dynamics of the situation. Towards the end of the interview, I returned to the subject of supervision.

1 Lisa: And you say you have an AMHP manager now. Does that help?

2 Rose: It does in supervision with cases but obviously she's more health  
3 aligned as a manager.

So even though Rose is managed by a social worker, the fact that she is employed by the Health Trust means that 'obviously she's more health aligned as a manager'. This means that having a social work manager is no longer a guarantee of *social work* supervision. In other words, having a manager who comes from a social work background is no longer a guarantee that the complete process of social work supervision – reflection and emotional support – will be enacted. This connects with the conclusion of Eileen Munro's (2011) final report into child protection services:

A common experience amongst social workers is that the few supervision opportunities are dominated by a managerial need to focus on performance, for example, throughput, case closure, adhering to timescales and completion of written records. This leaves little time for thoughtful consideration of what is happening in the lives of children and their families. (Munro 2011 p.118)

The second extract about supervision comes from the interview with Grace. Grace had been talking about her first job as a qualified social worker when she had a 'terrible' nurse manager.

1 Grace: Looking back and I think again looking at [pause] what I do now is  
2 [pause] I didn't have a lot of supervision. I had a very difficult  
3 relationship with the senior social worker at the time who umm I didn't  
4 get on with very much. Nice guy. We just didn't see eye to eye really. We  
5 weren't linked in with any other social workers. We weren't linked in we  
6 were in the attic of a big old school building so we were the weird  
7 relative in the attic so you never saw anyone. So I was really isolated. I  
8 wasn't an AMHP so I wasn't going to – well, ASW back then – umm and I  
9 just didn't get to see anyone at all. So I didn't get any career I asked for a  
10 career umm discussion and didn't get anywhere. Umm so never really  
11 have anyone leading me along really at all so it was really isolating.  
12 Horrible.

13 Lisa: Yeah and how did you maintain your social work identity during  
14 that time?

15 Grace: I clung on to the values. I clung on to an idea of what I thought a  
16 social work role would be and I carved it out

17 Lisa: It came from you

18 Grace: Definitely.

Through this story, Grace described not having social work supervision as leaving her feeling 'really isolated' (line 7). By mentioning that she had a 'very difficult relationship with the senior social worker' (line 3), Grace is tacitly indicating that she was unable to access peer supervision. Her description of the two social workers as being the 'weird relative in the attic' adds a dramaturgical dimension to the story, echoing the character of Mrs Rochester in 'Jane Eyre' (line 6). It places Grace and the

senior social worker as outsiders in the team. In addition, the allusion to madness is apt when the building contains a mental health team. While this might seem to go beyond an ethnomethodological analysis of 'the objective reality of social facts', it may be seen as related to the documentary method of interpretation. Here Grace presupposes that we both subscribe to this common sense knowledge. In addition, Harvey Sacks (1992 vol. 2 p.323; pp.397-400) discussed what he called the 'poetics' of ordinary talk. He described how speakers produce 'flurries' of words and phrases which resonate and juxtapose. Again, by mentioning that she was *not* an Approved Mental Health Professional/Approved Social Worker (lines 7-8), Grace is alluding to our shared knowledge that if she had been she would have been able to access peer supervision (in the way described by Rose above). As well as the lack of social work supervision leading to isolation, Grace also presents supervision as strongly associated with professional and personal development (the same connection that was implicit in my question to Rose).

In the coda to the story, Grace reiterates that the lack of supervision 'was really isolating. Horrible' thus ensuring that I have fully grasped the point that the story has served to illustrate (line 11). My response demonstrates my understanding through my affirmation and my question about social work identity (line 12). The question displays my assumption that having social work supervision is essential to making social work visible and accomplished as a routine orderly event (Pithouse 1984 p.15). Grace's response displays the tacit assumption that maintaining a social work identity is implicitly bound with social work values. The phrase 'I clung on' (line 14) is repeated twice and is evocative of the phrase 'I clung on for dear life' suggesting an urgency or desperation. There is also a balance in the beginning and end of this answer ['I clung on... and I carved it out'] which adds depth to the words (lines 14-15). Here Grace accomplishes a sense of being proactive and assertive; a significant theme in all of the interviews. My statement, 'it came from you' (line 16), both affirms Grace's account and presents social work as somehow intrinsic to the self, a notion which Grace then confirms ['Definitely'].



#### 4.3.3.1 The research interview as surrogate supervision

In the analysis of the interview with Rose above, an allusion was made to the significant difference between the interview-interaction and the supervision Rose described with the nurse manager. Rose was not able to make social work visible and accomplished as a routine orderly event in supervision with the nurse. However, this *was* possible in the interview-interaction because of our shared competence in doing being social workers. The final extract in this section about supervision is from the very end of the interview with Paul. I have finished asking all my questions and ask Paul if he would like to add anything.

- 1 Lisa: That's brilliant thank you. Is there anything that you wanted to add?  
2 Anything that you think I haven't covered?
- 3 Paul: No I think we're covered quite a lot [both laugh]. No it's good. I  
4 think in itself, you know, being interviewed it's nice just to get away from  
5 the office and the phones ringing and the questions being asked and just  
6 talk about my experiences and having you to facilitate that in itself is as  
7 good as a supervision. Oh there is an argument to say that umm and use  
8 that undertaking research which I've only done once before is kind of is a  
9 good opportunity to talk about your work is quite beneficial to your own  
10 well-being because you're talking to someone independent, impartial,  
11 objective, confidential and it's going towards some research study which  
12 is good in itself. I feel better just for talking so it's good so that's mutually  
13 beneficial [both laugh]

Here Paul makes a link between the interview and supervision: 'being interviewed... in itself is as good as a supervision' (line 7). Paul talks about taking time from the demands of the office (line 5) to talk about his 'experiences' (line 6) in the interview-interaction as 'beneficial' to his own 'well-being' (line 9-10). In this way the interview-interaction can be seen as mirroring one of the most fundamental components of supervision: the opportunity to reflect. Paul was the only social worker who explicitly made this link – and it is not something that I had considered before. However, the interview as a space for the social workers to reflect on their thoughts and experiences was one of the objectives of the research from the very beginning. Many of the social workers spoke of the difficulties and dilemmas that

they had experienced. One social worker, for example, told me that three people on his caseload had recently died in quick succession. In the interview-interaction, we mutually recognise each other as competent members and so are able to make social work visible through our talk.

To conclude this discussion, not only were the social workers isolated within Health Trusts but they were unable to make social work visible through supervision if they did not have a social work manager. This means that social work is not accomplished as a routine orderly event and so remains invisible (Pithouse 1984 p.15). Social work is not 'seen' by the other members of the team. However, one way that social work *is* made visible has been touched on in this section. Both Grace and Rose alluded to the importance of peer supervision, particularly in relation to AMHP work. However, this is dependent on the availability of other social workers and making personal contacts rather than being built into the structure of the Health Trust. Another way the AMHPs might receive social work support would be through links with the Local Authority. This will be explored in the next section.

#### **4.3.4 Maintaining links with the Local Authority**

Several studies in the Literature Review Chapter (Duggan 1997; Blinkhorn 2004; Huxley et al. 2005; Jackson and Hewitt-Moran 2009) identified that mental health social workers retained only minimal links to the employing Local Authority. To recap, the social workers in the study by Blinkhorn (2004) felt professionally isolated as they had been 'hived off' to the Trust without an effective link to the Social Services Department. This link was identified as important by Jackson and Hewitt-Moran (2009) in order that social workers are able to maintain their unique value base. Duggan (1997) explored the difficulties arising from the new managerial structures established by CMHTs. She found that the traditional profession-specific managerial structure had become blurred (Duggan 1997 p.23). Finally, Huxley et al. (2005) observed that there was poor integration of social services and NHS trust at management level and a lack of support for social workers in the teams. All of the

social workers interviewed for this research project that were seconded to Health Trusts remained employed by the Local Authority. This could be problematic. For example, Nell described the dual pressures of being employed by the Local Authority but working in the Health Trust as being 'Between a rock and a hard place'. None of the social workers seconded to a Trust described having strong links with the Local Authority. Andrew, for example, described the 'very small links' (line 5 below):

1 Lisa: Right, ok and when you, so do you feel that you're not linked to  
2 [name] council anymore then?

3 Andrew: No, no

4 Lisa: Not at all?

5 Andrew: [pause] very small links. We've drifted right over to the Trust  
6 now. We are firmly seated within the Trust umm I always just feel that  
7 [Local Authority] pay my wages and that's it.

Using evocative language, Andrew describes how the social workers have 'drifted' away from the Local Authority to become 'firmly seated' in the Health Trust. For Andrew, the role of the Local Authority is reduced to simply paying wages. Cath also described moving 'further and further away from services within the local authority'. I ask her to clarify this point:

1 Cath: We had a local authority manager and I think that we felt more,  
2 that we always knew what was happening within the local authority and  
3 that we moved separately but along the same path. Now I think we feel  
4 that we are here somewhere umm and trying to keep those links and  
5 that is something that I have been trying to do within my new role.  
6 Particularly around mental capacity and safeguarding saying that we  
7 need to link with you more closely because we sort of need to follow  
8 your path and not be separate to it. So in a way I suppose that's my  
9 attempt. Because we've not got a local authority manager now. We are  
10 totally managed by health. We don't attend team meetings for the local  
11 authority so that things that affect services in the local authority that we  
12 should be knowing about, we're not.

Like Andrew, Cath uses language about 'movement'. She describes the Local Authority and Health Trust as initially moving 'separately but along the same path' (line 3) and needing to 'follow your path and not be separate to it' (line 7-8), particularly in terms of 'safeguarding' and 'mental capacity'. However, this is no longer the case and Cath uses two curt sentences to narrate this ending ['Because we've not got a local authority manager now. We are totally managed by health.']. Although having links with a manager from the Local Authority was originally built into the management structure, once this person left, no-one was recruited to the post. Cath described the current position:

- 1 Cath: Umm now the highest person we've got an Assistant Director umm
- 2 who is health and social care but obviously there's a huge gap between
- 3 us and her. So the senior managers in between are health. I mean
- 4 they're great but you do feel that you need that social work perspective.
  
- 5 Lisa: Umm. So who does your supervision?
  
- 6 Cath: A health manager.

Now there is a 'huge gap' between the social workers in the CMHT and the Assistant Director in the Local Authority, with all the senior managers being from 'health'. Cath concludes that you 'need that social work perspective'. Again, the lack of any social work management in the organisational structure means that Cath has supervision with a health manager.

Thus, like the studies in the Literature Review, the social workers in my project are separated from other social workers with minimal links to their Local Authority employers.

The final part of this chapter will examine some of the themes identified by the social workers around the abolition of the unique to social work role of the Approved Social Worker and the introduction of the role of the Approved Mental Health Professional which is also open to nurses, occupational therapists and psychologists.

## **4.4 From Approved Social Worker to Approved Mental Health Professional**

### **4.4.1 Introduction: the nurse as other**

The interviews contained a great deal of talk regarding the abolition of the role of the Approved Social Worker and the introduction of the Approved Mental Health Professional. The main focus of the social workers was on the possibility of nurses becoming AMHPs. None of the social workers thought that psychologists or occupational therapists would train as AMHPs. This has proved to be an accurate assumption. The General Social Care Council (2012) found that since the AMHP role was introduced in November 2008, 84% of the candidates who successfully completed the training were social workers; 15% were nurses; 1% were occupational therapists; and there were no psychologists.

A number of themes were raised in the interviews regarding nurses becoming Approved Mental Health Professionals. For reasons of space, each theme will be summarised and illustrated by an example from the interviews. It is important to note that the focus here is how the comparisons with nursing position social work. The intention is to articulate the misgivings about nurses becoming AMHPs offered by the social workers interviewed for this research project.

### **4.4.2 Themes from the interviews**

The overriding view expressed by the social workers was that AMHP work should remain a social work role and that nurses would not make good AMHPs. The main argument for this position related to the relationship each profession has with the doctors who make the recommendations for treatment under the Mental Health Act 1983. This argument is as follows: social workers are employed by the Local Authority and are thus independent from doctors and so are in a position where they are able to question their decisions. In contrast, nurses are positioned in a hierarchical relationship with the doctor within the medical model and so would not

be able to challenge the doctors' decisions. This view was presented by Ed. Although my question asked about nurses *and* OTs, Ed's reply is only concerned with nurses.

1 Ed: There's a lot of other factors, aren't there? Because umm  
2 traditionally [pause] and this is going to could be a little bit judgemental  
3 a nurse in the hierarchy would feel below the doctor so very often if the  
4 doctor was to make a first recommendation about someone we as social  
5 workers we can challenge them. Nurses don't come from that  
6 background or ethos. There's also the pay structures. I work for the  
7 council and the section seventy five or whatever it is. A doctor could say  
8 to me or I could say to a doctor "*no I don't think this is a good idea*". Now  
9 if in the pay structure they have got no say over me. You know they can't  
10 recommend that I get fired or whatever. [laughs] They probably could  
11 but do you know what I mean? I think that there is the structure. Nurses  
12 are in the

13 Lisa: Same organisation.

At the beginning of his reply, Ed acknowledges that this position might sound 'a little bit judgemental' (line 2). Through his 'indexical' reference to a 'first recommendation' (line 4), Ed is explicating that the contrast that he is making between social workers and nurses is about undertaking a Mental Health Act assessment. When a doctor makes a first recommendation, this means that they have signed a form to say that a person meets the legal and medical criteria to be compulsorily admitted to hospital under the Act. Here nurses are positioned as feeling 'below' the doctor in a hierarchy within the medical model and so not able to challenge the doctor's decision (line 3). In contrast, social workers come from a different 'background and ethos' [the social model] so are able to challenge the doctor (line 5). Here the use of 'we' ['we as social workers we can challenge them'] serves a dual purpose. It affirms our shared membership and provides authority through a collective 'authorisation' of his argument (Smith 1978), i.e. that it is not just him but all social workers that are able to challenge doctors. Again, this claim links in with the wider theme of social workers as assertive.

Ed then provides another contrast in terms of the 'pay structures' of social workers and nurses (line 6). Ed is employed by the Local Authority and is seconded to the

Health Trust: his reference is to Section 75 of the National Health Service Act 2006 on partnership working (line 7), whereby the partners can join together their staff, resources, and management structures to integrate the provision of a service. Thus Ed is positioning himself as independent from the doctor and so is able to question their decision; here the use of active voicing provides emphasis to his account (line 8-10). In contrast, nurses are in the same structure as doctors with the implication being that they are not independent and so not able to question. This point and the next section of the interview are co-narrated:

- 1 Ed: Nurses are in the
- 2 Lisa: Same organisation
- 3 Ed: And we know that. We know the hierarchy. How the hierarchy  
4 operates within medical models, you know, there's books written about  
5 it
- 6 Lisa: And you feel separate to that? You feel that we are separate to  
7 that?
- 8 Ed: For the moment, for the moment. I wonder if it will change if it  
9 would change if we were if we had health contracts.
- 10 Lisa: Because some people have, some social workers have
- 11 Ed: Increasingly more and they are looking at bringing them in and  
12 whether that's going to change things. I mean social workers  
13 traditionally within health care settings have had a lot of independence.  
14 That's one of the reasons that it appealed to me because as a social  
15 worker we have the ability to challenge people and that's another  
16 reason why it was traditionally our [pause] our area to do all the  
17 detentions and stuff, you know.

Again, this ability to co-narrate during a first meeting can be seen as a powerful display of our shared occupational membership. As well as co-narration, our collective membership is again affirmed by the use of 'we' throughout this section (lines 3, 6, 9 and 14). The reference to 'books' (line 4) strengthens the claim made about the hierarchy within the medical model through independent 'authorisation'

(Smith 1978). Returning to his earlier points, Ed reiterates that 'traditional' social work is distinct in terms of 'independence' (line 13) and 'the ability to challenge people' (line 15). Ed then associates these qualities with being an AMHP ['that's another reason why it was traditionally our [pause] our area to do all the detentions and stuff, you know']. Thus, this extract denotes social work as the most appropriate profession to undertake the AMHP role.

The second theme concerned the differing training of nurses and social workers; namely that social workers are trained to work within the social model whereas nurses are trained within the medical model. The following extract from the group interview demonstrates the way that a group of members work collectively to produce a coherent and recognisable institutional identity by such devices as co-narration, laughter, and independent authorisation.

1 Lisa: And when you all heard that the ASW role was going to be widened  
2 to health professionals, what was your reaction?

3 Isobel: It's very interesting because on your course there were going to  
4 be health professionals on your course and none of them completed it

5 Lucy: none of them completed it

6 Lisa: Really?

7 Lucy: I think they I'm not sure I think that one of them did umm that was  
8 from another authority but there were quite a lot of health professionals  
9 on and very very few of them in fact I think the majority were health  
10 professionals there were only three of us you know from the council. But  
11 none of them apart from maybe one completed the training. Some of  
12 them dropped out half way some of them didn't expect you know it  
13 wasn't what they expected the course and they struggled with the social  
14 care side

15 Isobel: it's the evidence side the values and principles that social workers  
16 just do

17 Karen: they've never had that bit, have they?

18 Lucy: no no.



Here Isobel refers to the AMHP training course that Lucy has recently finished and states that none of the health professionals completed the course. Lucy mirrors Isobel's statement (line 5). However, when asked for clarification, she goes on to state that perhaps one health professional did; that this is a 'dispreferred' response is indicated by her uncertain and disorganised response. Lucy then uses 'extreme case formulation' to strengthen her answer: out of the 'majority' of health professionals on the course 'none of them apart from maybe one' completed the training (line 9-11). Lucy's description that the health professionals 'struggled with the social care side' is extended by Isobel ['it's the evidence side the values and principles that social workers just do']. The implicit contrast that Isobel is making here between social workers and health professionals is affirmed by Karen and Lucy: social work is associated with 'evidence', 'values and principles' (line 15) whereas health professionals have 'never had that bit' (lines 17). John then widens the discussion to include the AMHP training course that Karen recently completed.

- 1 John: you had one on your course didn't you?
- 2 Karen: I did and he lasted about a week or two weeks and then left. He  
3 was a CPN and he left because he didn't realise, well his managers didn't  
4 realise that he had to attend more than once every blue moon and they  
5 didn't realise there was any written work to do which I thought said it all  
6 really [all laugh]
- 7 Lisa: And so these people just couldn't adjust to that way of thinking
- 8 Lucy: no. Like I say there was one or two of them that were very good  
9 but the rest of them no not at all. And so if they went along with the  
10 philosophy so "*if we went out to assess somebody we would tell them*  
11 *they had to go into hospital*". They wouldn't look at any of the  
12 alternatives
- 13 John: they couldn't adjust to that social
- 14 Karen: and without some social work training I just don't know how you  
15 could do the course
- 16 Lucy: no, I don't.

Here the description of a person as 'one' ['you had one on your course'] has somewhat negative and distancing connotations. Karen continues the narrative with an atrocity story about a CPN [Community Psychiatric Nurse] whose managers are presented as completely unaware of the content of AMHP training (line 3-6). The collective laughter at the expense of these managers both displays and affirms our shared institutional affiliation (line 6). Like John's description earlier, my term 'these people' is a distancing device, depicting the health professionals as 'outsiders' (line 7). After acknowledging that one or two of the health professionals were 'very good' (line 8), Lucy continues by using active voicing to depict the nurses as authoritarian. Again, it is very unlikely that the nurses as a group would have actually said these words. The allusion to 'alternatives' (line 12) refers to the duty of AMHPs to consider if there is an alternative to compulsory admission using the social perspective. Thus, unlike social workers, the CPN is depicted as authoritarian and as not considering the social perspective of considering alternatives to detention under the Mental Health Act. John endorses the story ['they couldn't adjust to that social'] which is then extended in a co-narration by Karen who states that 'without some social work training I just don't know how you could do the course' (line 14-15). Thus, like Ed, Karen is claiming that only social workers can become AMHPs, a point that is affirmed by Lucy (line 16).

The third theme builds upon this idea of nurses as authoritarian. In contrast, to nursing, social work is presented as distinctive in terms of social justice and the empowerment of service users. I ask Cath if she was 'worried about' the introduction of the AMHP role.

- 1 Cath: Yes I have to say because with the best will in the world [pause]
- 2 your social work training instills in you different professional values and
- 3 as individuals these physios and nurses I'm sure have got those qualities
- 4 as people but sometimes as a professional [pause] I don't always feel
- 5 that it's part of the professional skill set, if you know what I mean, or
- 6 part of the professional value base. It's more hierarchical, it's more
- 7 about "*doctor says we'll do this*", less independent sometimes umm

- 8 [pause] yeah I have to say that it does concern me. Because if I'm very  
9 blunt I don't think that they think like we do
- 10 Lisa: No, no, no, no. And again, do you think that comes from our  
11 training?

Here Cath contrasts the professional values that social work training 'instils in you' (line 2) from the professional skill set or value base of nurses and 'physios' (nb. physiotherapists are not able to become AMHPs). The term 'instils in you' implies that the values become intrinsic to the self for social workers. In contrast, while nurses and physiotherapists might have those 'qualities as people' (line 3-4), this is not apparent in their professional identity (line 4-6). Like Ed above, Cath depicts the nurses and physiotherapists as part of a hierarchy within the medical model; as following the orders of doctors; and as less independent. In a key phrase, Cath states that 'if I'm very blunt I don't think that they think like we do' (line 8-9) which clearly places nurses and physiotherapists as the 'other'. My repeat of 'no' four times (line 10) displays my shared social work identity in an endorsement of her claim and my use of the collective pronoun 'our training'. In turn, Cath endorses my statement by repeating 'yes I do' (line 1 below).

- 1 Cath: Yes I do. Yes I do, yeah definitely cos, cos like I say, as individuals  
2 we couldn't maybe view things in a certain way in the way we treat  
3 people maybe in a person centred way but then when you look at your  
4 professional values and your decision making, I think that social work is  
5 very good at standing up to medical professionals, aren't they? And  
6 nurses sometimes aren't. They'll just defer to them and say "*such a body*  
7 *told me to do that*" whereas I won't do that I might say I'm not sure I  
8 agree with that. Umm so that was one concern that I had
- 9 Lisa: And can you articulate, as again it's really hard to say what is social  
10 work, what is the difference?
- 11 Cath: Umm [pause] that it's not a medical perspective, is it? It is a social  
12 perspective and you have a duty to question umm [pause] I think you  
13 have a duty to question other professionals that may be more imposing  
14 rather than collaborative, if you see what I mean. And again with the  
15 best will in the world the medical profession is more imposing rather  
16 than umm bringing someone along. I don't know if I can articulate it to

17 be honest clearly but I do think it's something that in social work we do.  
18 It's the advocating too, isn't it, it's the [pause] it's things like you work  
19 with someone who lives in a housing complex say a flat complex who has  
20 mental health problems – everybody knows that they do and they don't  
21 like it. There's a stigma and people make judgements. You are constantly  
22 battling with wardens, relatives, neighbours things like that because they  
23 may appear a little odd, a little bit bizarre behaviour. You're constantly  
24 battling for that person and their rights to stay in a place or to live their  
25 life. In a sense that [pause] that's never been another profession's role,  
26 has it? That's always been our role to [pause] I don't know, it's about  
27 helping people stand up for themselves against the odds, isn't it? That's  
28 the only way that I think I've got a bit of an analogy about it, really.

Cath represents social work identity as developing from social work education rather than the individual person already viewing 'things in a certain way' (line 2). Again using active voicing, Cath contrasts social workers and nurses: social workers are assertive with doctors in contrast to nurses who are deferential (line 4-8). When asked to elaborate on what is distinctive about social work, Cath contrasts the social perspective of social work with the medical perspective of health professionals (line 11-12). Again, she positions social workers as assertive and health professionals as 'imposing rather than collaborative' (line 13-14). This point is then reiterated ['the medical profession is more imposing rather than umm bringing someone along'], contrasting the authoritarian medical model with the empowering social model. Cath struggles again to define what social work is: 'I don't know if I can articulate it to be honest clearly but I do think it's something that in social work we do' (line 16-17). This is another example of social work as somehow intangible, which was discussed in Chapter 5.

In the final part of the extract, Cath uses a story about a service user to illustrate her point that social work is bound with advocacy (line 18-27). Through this story about the stigma of mental distress, the social worker is presented as 'constantly battling' (a phrase that is used twice) other people on behalf of the service user and their rights. Here, again, social workers as presented as assertive. In a key phrase, she concludes:

1 Cath: In a sense that [pause] that's never been another profession's role,  
2 has it? That's always been our role to [pause] I don't know, it's about  
3 helping people stand up for themselves against the odds, isn't it?

Thus, through this story, Cath is presenting the distinctiveness of social work in terms of social justice and the empowerment of service users.

The fourth and final theme presents nurses as being controlling, unable to deal with risk and as having a narrow focus. In contrast, social workers as presented as working holistically, enabling service user choice and as comfortable in managing risk. This is illustrated by an extract from the group interview.

1 Isobel: They want to control they don't want to live with the fact that  
2 Mrs Jones might be a bit of a risk because she does certain things: "*I*  
3 *want to control put that person into care because I don't feel safe*" and  
4 that is the difference between how social workers live more comfortably  
5 with people having choices and living independently whereas a nurse will  
6 say "*in my view*"

7 Lucy: they don't feel comfortable in managing any risk really do they?

8 Karen: and they don't understand about choice do they or capacity or  
9 anything like that

10 John: I think again and it's going back to and I have said this to Lisa about  
11 being prescriptive "*this person can't do that so they need to do this*" you  
12 know rather than "*well it's difficult but I accept what you're saying*" but  
13 no they say "*no, no that's the decision. I'm a nurse. You can't do this and*  
14 *you've got to do this*". And I know I'm being very general but

15 Tim: but I think that's what social work is about John. It's about one size  
16 doesn't fit all and it's what we struggle with you know I had a really  
17 complex meeting and I had to support an assessment officer during the  
18 week with a really, really complex shitty case and it was about poor  
19 clinical judgement and decision making to give someone twelve weeks  
20 prescriptive rehabilitation and one size fits all and the person's not quite  
21 ready and they were young and we were looking at residential care. And  
22 so we were having to look at best interests and go and force the issue to  
23 the point where we were actually questioning the professionals the  
24 nurses, the OTs, the speech and language therapists, the occupational  
25 therapist, their professional assessments really and basically they said

26        “are you questioning our assessments?” and collectively they come  
27        together at you as a team like this big wall and you say “yeah. I am”

28        [all laugh]

29        Tim: you know and then it goes to a higher level up where managers  
30        have ding dongs and everything and big fallouts really. And that is, going  
31        back to social work theory, you don’t put one glove on and I think it was  
32        David Howe his book wasn’t it his social work theory book that said  
33        “there’s more than one way to skin a cat” and that’s social work theory  
34        in a nut shell really and there is you know well “how am I going to look at  
35        it today, how am I going to approach it?” and that’s the beauty of social  
36        work and perhaps nurses don’t get it because they just work to one  
37        prescriptive model of treatment really I know the holistic approaches are  
38        there or thereabouts but they’re not there because you are waiting two  
39        years for a referral to psychology to come through you know so what  
40        alternatives have you got really and you’re dealing with crises aren’t you  
41        really you know

42        Lucy: well they don’t take a holistic approach to anything really do they  
43        or the majority of them anyway

44        Tim: I just feel so uncomfortable in it really. It’d be like being in  
45        somebody else’s bed – I know how I like my sheets

46        [all laugh]

47        Tim: and I know what number I want the electric blanket on. And that’s  
48        not about control that’s about feeling comfortable

49        [all laugh]

This lengthy extract from the group interview also represents nurses as other. In a contrast structure, Isobel presents social workers as comfortable with risk, independence and choice compared with nurses who ‘want to control’ service users and do not want to live with risk (line 1-6). Again, Wooffitt’s (1992) term ‘active voicing’ is accurate here as it is extremely unlikely that a nurse would actually say “*I want to control put that person into care because I don’t feel safe*” (line 3). Lucy validates Isobel’s depiction that nurses are not comfortable in managing risk and then Karen extends this in a co-narration to present nurses as not understanding the concepts of ‘choice’ and ‘capacity’ (line 8). Through my ‘deep competence’ (ten

Have 2002), I recognise that assessing capacity is key in social work. Since the implementation of the Mental Capacity Act 2005, social workers have to work within a legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make specific decisions for themselves.

John continues the discussion by again contrasting social workers and nurses, using active voicing in an interaction to emphasise his point (line 11-14). Nurses are presented as 'prescriptive' and authoritarian [*"You can't do this and you've got to do this"*] compared to social workers who accept the views of services users [*"well it's difficult but I accept what you're saying"*]. By conceding that he is being 'very general but', John can be seen as adding credibility and plausibility to his assertions.

Tim then co-narrates the story by extending John's sentences through the use of 'but' (line 15). He provides a definition of social work: 'It's about one size doesn't fit all and it's what we struggle with you know'. Thus social work is presented as non-prescriptive and as recognising that there is no standard or prescribed way to approach people. Tim then illustrates his point through introducing a narrative about a 'complex meeting' (line 17). The health professionals (nurses, occupational therapists, and speech and language therapists) show 'poor clinical judgement and decision making' by giving 'someone twelve weeks prescriptive rehabilitation and one size fits all' (line 19-20). Thus in a contrast structure, social workers are non-prescriptive and one size 'doesn't fit all' (15-16) compared to health professionals who are prescriptive and 'one size fits all' (line 20). Here the use of specialised vocabulary ['we were having to look at best interests'] is a way of accomplishing a collective social work identity: we all understand that a social worker undertakes a 'Best Interest's Assessment' under the Mental Capacity Act 2005. In this story, the lone social worker is positioned as questioning the health professionals ['collectively they come together at you as a team like this big wall']. The use of active voicing in an interaction adds to the vibrancy and the drama of the story (line 26-27). Through shared laughter, the group affirms our shared institutional affiliation (line 28).

Tim then re-orientates the narrative back to his definition of social work as 'one size doesn't fit all' ['And that is, going back to social work theory, you don't put one glove on']. Through his allusion to a shared social work reference - the book by David Howe - Tim again affirms our collective membership (line 32). He then defines social work as "*there's more than one way to skin a cat*" ... "*how am I going to look at it today, how am I going to approach it?*" (line 33-35). Through this definition, Tim is reiterating his argument that the 'beauty' of social work is the use of a flexible non-prescriptive approach to working with service users. In direct contrast, nurses 'just work to one prescriptive model of treatment really' (line 37). Tim acknowledges that holistic approaches are available, but then he goes on to make the point that psychological treatments are not available immediately which leads to crisis management (37-40).

Lucy validates Tim's statement and extends his use of the word holistic to the term 'holistic approach' (line 42). As members of the social work trade, we recognise that social workers are trained to take a holistic approach to assessing the needs of service users. In contrast, Lucy describes nurses as not taking a holistic approach, with her caveat adding to her credibility (42-43). This segment of the interview ends with Tim using a humorous simile about prescription ['It'd be like being in somebody else's bed – I know how I like my sheets [all laugh] and I know what number I want the electric blanket on']. Again, humour and shared laughter both display and affirm our collective institutional identity.

This section has examined the main themes from the interviews concerning the introduction of the AMHP role. Again, it was nurses who were positioned as other. It is through these contrasts that the social workers depict what is 'real' social work. Furthermore, the social workers also identified the introduction of the AMHP role as a step in the demise of mental health social work and this will be examined in the final part of this chapter.



### 4.4.3 Introduction of the AMHP role as a step in the demise of mental health social work

Many of the interviewees saw the introduction of the AMHP role as signalling the beginning of the demise of the social work profession. I did not ask a specific question about this. Rather my final question to all the interviewees was about the future of mental health social work and it was at this point that this matter was raised by the social workers themselves. This section will examine some of these replies. Grace replied that there will be a move to generic working.

- 1 Lisa: And the last question from me – you may have something to add –  
2 is how do you see the future of mental health social work?
- 3 Grace: I'm really frightened for it. I'm really concerned that it's going to  
4 get lost in the ether umm as this whole care co-ordinator homogenous  
5 title and it gets pushed out. I think they are hoping that more more  
6 nurses are going to want to be AMHPs and I think that's not in my  
7 experience that's not going to be the case. I don't think they're going to  
8 want to do that I don't think. It's a respectful role and I think what's  
9 concerning me is that people will be expected to do it as part of their  
10 training and development. I don't understand how you can expect  
11 people to exercise that if they're not truly taking on the whole spectrum  
12 of responsibility of role and value that comes with it. I am frightened that  
13 social work's going to get squeezed out [pause] I am concerned.

Grace uses evocative imagery to describe the future of social work: social work will be 'lost in the ether' (line 4), 'pushed out' (line 5) and 'squeezed out' (line 13). Grace also expresses the emotional impact that this proposed change has on her: her answer both begins and ends with her saying that she is 'concerned' (line 3 and 13) and 'frightened' (line 3 and 12). Once again, the nurse is the other – the only profession singled out as potentially taking on the AMHP role (line 6). Here the AMHP role is intimately bound with being 'respectful' (line 8), responsible (line 12), and value-led (line 12). The nurses would 'be expected to do it as part of their training and development' (line 10) without 'truly taking on' these (social work)

qualities associated with being an AMHP (line 11) in the way that a social worker would (as discussed earlier in the section on social work as intrinsic to the self).

In her response to the same question, Rose seems to struggle to answer with long pauses and the phrases 'Oh gosh' and 'err let me think' (line 1 below).

- 1       Rose: Oh gosh. [long pause] I think it'll become more err let me think  
2       [long pause] there's so many changes going on at the moment. I think it  
3       will [pause] I mean there's plans for us to be the AMHP service to come  
4       under health. I don't know how far along that is but if that happened  
5       which I hope it doesn't but that we'll become more aligned with health. I  
6       think we'll have to fight harder to retain the social work identity. Umm  
7       yeah I think there was talk about us coming under we'd be regulated  
8       because I think already it's started that the GSCC is
- 9       Lisa: Umm is moving to the Health Professions Council
- 10       Rose: Yeah so I don't know what that will. It might not have any impact.  
11       Often these changes are not as umm as big as they're anticipated to be  
12       but yeah I'm not sure. That could be quite worrying.

Rose describes working in a situation of transition ['there's so many changes going on at the moment']. Like Grace, Rose depicts social work as becoming more associated with health, with plans for the AMHP service being moved to the Health Trust (line 3-4). Rose evokes an image of social workers having to 'fight' to retain their identity in a health dominated environment (line 6). Rose develops this premise by moving on to talk about the GSCC – the General Social Care Council. My completion of her sentence (line 8-9) shows that I have recognised her point that the regulation of social work is also going to be aligned with those of health professions. The GSCC has been abolished and regulation has been transferred to what is now called the Health and Care Professions Council (it is perhaps notable that the word 'Social' is not mentioned in the title). Rose makes the interesting point that changes often have less impact than anticipated (line 11). This has proved to be an accurate observation as the numbers of nurses, psychologists and occupational therapists choosing to train as AMHPs have been fairly minimal. Finally, Rose ends her reply with the coda 'that could be quite worrying' (line 12).

Eva also discussed the introduction of the AMHP as leading to a more generic mental health worker role.

1       Eva: Certainly it's not I don't think that social work in mental health is  
2       going to flourish and grow and take over and it's all going to be lovely. I  
3       imagine we will be it will be a continually attacked role, a marginalised  
4       role. [long pause] Umm I suppose I view that in the context of all  
5       services. I wouldn't say that particularly social work is going to be  
6       attacked umm [pause] I wouldn't have thought. I suppose the future we  
7       will become generic workers they will advertise for mental health  
8       workers and they won't care what we are because there's no reason for  
9       them to hire a nurse or a social worker now particularly with the AMHP  
10       thing changing it doesn't matter they just need people in carrying the  
11       caseloads so it doesn't matter to them what we are. Umm so [pause] it'll  
12       be interesting won't it.

Eva imagines that social work will be a 'continually attacked' and 'marginalised' role in the future (line 3), but this will also apply to 'all services' not just social work (line 4-5). She makes the point that now that the AMHP role has been introduced, there will be a move to a generic mental health worker ['they won't care what we are because there's no reason for them to hire a nurse or a social worker now']. This view concurs with the Department of Health's New Ways of Working Programme (2004; 2005; 2007) where there has been a move away from traditional roles to the emphasis being placed on competencies and capabilities. Consider the following extract on workforce planning:

In the future, with the emphasis on competences and capabilities, workforce planning will become more complex. For example, it will no longer be appropriate simply to say we have a nurse or occupational therapist staff vacancy, so we should automatically recruit another nurse or occupational therapist. (Department of Health 2007)

The final extract on the issue of the introduction of the AMHP role having an impact on the future of mental health social work is from the interview with Paul. Again, I have asked Paul how he sees the future of mental health social work.

1 Paul: I think there's um more and more well I don't know about numbers  
2 but now we have the umm social work and nursing degree [pause] umm  
3 I think [pause] the emphasis in recruitment is um children and families  
4 because of the huge vacancies there and I can see it being quite split that  
5 eventually I don't agree but I think social work training will be split and it  
6 will no longer be generic and it will either be children's and families or  
7 kind of a health and I think maybe err that will be a kind of moving  
8 towards a combined health, nursing and social work. I don't know how  
9 long that will take - ten years' time? I can imagine more and more  
10 mental health social workers will be nursing trained as well because  
11 we're just being incorporated into the NHS and that's their way of  
12 working. It's a very medical model. Umm they don't exclude the social  
13 model. They see a benefit for it and that's why there's dual training but  
14 that's how I see mental health social work. And then everyone having  
15 the opportunity to train as an AMHP, you know, and I think almost to say  
16 the old guard will remain and then eventually they will move on and  
17 then it will be a very kind of umm streamlined, efficient, managed, umm  
18 medical err profession rather than a core separate an unique  
19 autonomous social work profession.

At the moment all social workers do the same course with a specialist module in their chosen area (such as mental health; learning disabilities; children and families). Paul talks about the possibility of social work training being 'split' in the future (line 4 and 5) with separate courses in children and families and 'kind of a health' (line 6-7). Paul describes the latter as being a combined health, nursing and social work course with 'more and more mental health social workers will be nursing trained because we're just being incorporated into the NHS and that's their way of working' (line 10-11). Like Grace and Rose, Paul is presenting an image of social work as being incorporated into the health service. The social workers would then be working in 'a very medical model' although Paul argues that there would be also a place for the social model within this (line 12). Then within this model, all of the professionals would have the option to train as an AMHP. Finally, Paul states that once the 'old guard' (i.e. the present day social workers) leave, mental health social work 'will be a very kind of umm streamlined, efficient, managed, umm medical err profession rather than a core separate a unique autonomous social work profession' (line 17-18). Here Paul presents social work as 'separate', 'unique' and 'autonomous' being lost and social work as being subsumed into the medical profession.

To conclude this section, all of the social workers without exception saw the future of mental health social work as being difficult and challenging. As has been discussed, many of the interviewees saw the introduction of the AMHP role as the marking the beginning of the demise of social work. The social workers talked about a move towards a generic mental health worker, social work being 'lost' and subsumed into health.

#### **4.5 Conclusion to chapter**

The focus of this chapter has been on being an Approved Mental Health Professional (AMHP). Rather than being dirty work, the social workers considered undertaking AMHP duty to be a prestigious role. Indeed, it was seen as epitomising 'real' social work because it encompasses being autonomous; managing complex situations in the least restrictive manner; and being assertive on behalf of service users. However, it is clear that AMHP duty holds an inherent ambiguity. It is complex, challenging and emotionally difficult work which contains contradictions and tensions. In terms of the visibility of social work, the social workers are isolated within predominantly health teams with weak links to their Local Authority employers. This means that, in ethnomethodological terms, they are unable to make social work 'visibly-rational-and-reportable-for-all-practical-purposes' (Garfinkel 1967 p.vii). In addition, many of the social workers are unable to make social work visible through supervision (Pithouse 1984) as they are being managed and supervised by health professionals. Finally, the abolition of the distinctive-to-social-work Approved Social Work role and the introduction of the Approved Mental Health Professional role was seen as a step towards the demise of mental health social work.

## Part Two: Doing being a social worker: accomplishing a social work identity in research interviews

The analytic focus shifts in the second part of the findings chapters. Here ethnomethodology and conversation analysis will be used to examine *how* social work identity was accomplished *within the interview as interaction*. In order to set the scene, the chapter will begin with an overview of the use of ethnomethodology and conversation analysis in social work research. Following this, the first chapter in this section will explore matters such as ‘being a member’, the part played by the use of humour in the interviews, and the interaction *as a research interview*. One pervasive way in which social work was accomplished in the interviews was through the telling of ‘atrocious stories’. The use of this type of story will be examined in the second (and final) chapter in this part of the findings section.

## 5 Ethnomethodology and conversation analysis in social work research: an overview

The aim of this section is to give a brief overview of the use of ethnomethodology and conversation analysis in social work research. However, while ethnomethodology has been described at length in the methodology chapter, there has only been a brief description of conversation analysis and so a short introduction is necessary here. Conversation analysis was developed by Harvey Sacks (1935-1975) and involves the detailed analysis of naturally occurring talk. For Sacks, as for Garfinkel, conversation is fundamentally orderly. Dennis et al. (2013) described the three features of conversation identified by Sacks that form the 'bedrock' of conversational orderliness:

First, turn-taking occurs in conversation; second, one speaker tends to talk at a time; and finally, turns are taken with as little gap or overlap as possible (Dennis et al. 2013 p.68 emphasis in original)

There was a close association between the work of Harvey Sacks and Harold Garfinkel, including a key co-authored paper (1970). Although acknowledging that there is a 'certain ambiguity, and even ambivalence' in the relationship, ten Have (2004 p.25) treats conversation analysis as an example of ethnomethodology. For Paul ten Have (2004 p.26), what is studied in conversation analysis is not rules as such but rules as used by members in interaction. The emphasis placed by Sacks on the context-dependent nature of conversation 'may well be the strongest and detailed form of ethnomethodological description' (Dennis et al. 2013 p.155).

### 5.1 The database search

The review is based on peer-reviewed work published in journals. A scoping review of the use of ethnomethodology and conversation analysis in social work research on Swetswise and Wiley Online using the search terms ethnomethodolog\* AND "social work"; and "conversation analysis" AND "social work" identified a total of 16

articles. One article (Broadhurst 2007) that was not found during the search but which was already known was also included in the review.

Two of these articles did not report empirical research. Gerald de Montigny (2007) provided an overview of the value of EM for social work. He made connections between EM and social work practice, stating that Garfinkel has advanced 'an issue at the very heart of social work practice' (p.100). He gives the example of doing an assessment:

...we need to understand how it is that this client practically makes her life, in these places, and in interaction with others, such that the problem emerges. As in EM, social workers struggle to examine the largely ignored, taken-for-granted, routine, and overlooked. (de Montigny 2007 p.101)

Here the word 'emerges' is slightly confusing as it seems to suggest that the problem pre-exists within or with the client rather than being accomplished within an interaction. De Montigny (2007 p.111) made the important point that, for social workers, the 'inequalities between their power to produce professional accounts and that of clients provides a rich terrain for investigation'. Although at times the article can be difficult to follow, de Montigny (2007) has taken the lead in introducing ethnomethodology to social work researchers and practitioners.

The other non-empirical article was by Ian Shaw. Shaw (2003) presented ethnomethodology and symbolic interactionism as one of four ways that qualitative research can contribute 'indispensably' to outcomes research. He used two examples to illustrate this claim: Miller (1997) and Denzin (1989). Presumably, Miller is the EM example, although Shaw does not make this clear. Indeed, from Shaw's description, Miller's research seems more like ethnography; a term that is actually mentioned (whereas EM is not actually mentioned in relation to Miller's research).



## 5.2 Articles included in the review

Of the remaining 15 articles, the author(s) of 6 articles stated that ethnomethodology was used to analyse the data (Carey 2008; Forsberg and Vagli 2006; Hicks 2008; Rasanen 2011; Taylor 2008; Törrönen 2006); 8 stated that they used conversation analysis (Broadhurst 2007; Hall and Slembrouck 2011; Hitzler 2011; Messmer and Hitzler 2011; Noordegraaf, van Nijnatten and Elbers 2008; Solberg 2011; van Nijnatten 2005; White 2002); and 1 author stated that he used both EM and CA (Carey 2009).

The majority (10) of the articles were concerned with topics related to the field of children and families social work. For example, the article by Maritta Törrönen (2006) analysed what community means in the framework of a social network for young residents of a children's home. A further 4 articles were related to social work with adults. For example, the article by Malcolm Carey (2009) explored agency care managers' construction of social order within social work departments. The remaining article explored writing practices in social work. Here, Carolyn Taylor (2008) used EM and literary criticism to examine reports, case records and a reflective account. Notably, there were no articles in the field of mental health social work.

The authors of the articles reporting empirical research were all based in Europe: the UK (Karen Broadhurst; Malcolm Carey; Christopher Hall; Steve Hicks; Carolyn Taylor; and Sue White), Norway (Janne Solberg; and Åse Vagli), Finland (Hannele Forsberg; Jenni-Mari Rasanen; and Maritta Törrönen), Germany (Sarah Hitzler; and Heinz Messmer), Holland (Ed Elbers; Martine Noordegraaf; and Carolus van Nijnatten), and Belgium (Stef Slembrouck). This is likely to have been a result of only searching in two databases. However, the databases concerned do include journals which publish international work, for example, the *Journal of Social Work*. A systematic review of the literature would no doubt identify work from other countries.

### **5.3 Criteria for assessing the quality of the articles included in the review**

This section is concerned with assessing the quality of the 15 articles included in the review. In order to achieve this, it is necessary to introduce some explicit criteria as the basis of the assessment. The first criterion applies to both EM and CA research; other criteria will be applied separately.

#### **5.3.1 Interactional accomplishment**

As has been emphasised throughout the thesis, the focus of EM and CA is not on the individual person but is on detailed study of witnessable *interaction*. Thus, all research which claims to use EM and/or CA must retain the interactional accomplishment when presenting extracts from the data. Not all the articles met this requirement. For example, only two short extracts from interview data were included in the entire article by Carey (2009). Both of these extracts were taken from an interview with one agency social worker [‘Brenda’] and were not provided in the form of an interaction. Indeed, the extracts do not include the questions or input from the interviewer and so no attempt is made to show how the interview is accomplished. Here the focus is on Brenda as an individual.

In contrast, the talk as an interaction was included in all of the other articles which stated that conversation analysis had been used. For example, in her article about parental help-seeking, Karen Broadhurst (2007) acknowledged the role of the researcher in accomplishing the interview:

In this kind of analysis, the researcher's own normative orientation can also be a focus of analysis, with the researcher holding in common with co-participants, tacit categorical resources. (Broadhurst 2007 4.4)

Broadhurst found that the researcher used the same inferential resource as the members of the focus group.

### **5.3.2 Assessment criteria for the articles using ethnomethodology**

In order to review the studies where EM was used, the articles will be examined in relation to what are arguably the two most fundamental elements of Garfinkel's program. These are the use of the unique adequacy requirement of methods and ethnomethodological indifference.

#### **5.3.2.1 The unique adequacy requirement of methods**

The unique adequacy requirement of methods was only mentioned by one of the authors. In his study of family placement social workers, Hicks (2008) stated that:

In order to produce gender adequately, we must all become competent practitioners of it, we must develop 'unique adequacy' in the practical methods of gender. (Hicks 2008 p.52)

Unfortunately, this is not an accurate use of the term: it is only researchers who must become uniquely adequate; members need to become 'vulgarily competent' (Garfinkel and Wieder 1992 p.182). Even though it is not clear from the article, Hicks may well have been uniquely adequate in the weak sense if he had previously worked as a family placement social worker. Again, although it was not stated, other researchers may have met the unique adequacy requirement in this weak sense. For example, the research by Törrönen (2006), Carey (2008) and Rasanen (2011) were ethnographic studies which would suggest that they had become uniquely adequate. Although their article was based on the recordings of case discussions that the child protection workers themselves taped, both Forsberg and Vagli had undertaken previous ethnographic studies (see Forsberg, 1999; Vagli, 2001) on child protection practices. In this way, Forsberg and Vagli (2006) may well have met the unique adequacy requirement for EM researchers. It is notable that this fundamental tenet of EM research was ignored by these researchers even though they are likely to have met the requirement.

### 5.3.2.2 Ethnomethodological indifference

Only one of the articles made any reference to the policy of ethnomethodological indifference. Although she did not explicitly use the term, Taylor (2008) stated that:

Here I intend to bracket the making of normative judgements about the quality of records. I am less interested in whether they are 'good' or 'bad' than in the conventions used within this genre of writing to relay facts in an authoritative way. (Taylor 2008 p.30)

Thus, Taylor maintained EM indifference in this sense of the term throughout her analysis of writing practices.

The authors of three of the six EM articles stated that they had used EM alongside another approach to analysis. Hannele Forsberg and Åse Vagli (2006) used ethnomethodology and 'Goffmanesque' frame analysis as a tool to explore the central role of emotions within the daily work of child protection workers. Stephen Hicks (2008) specified that he used feminist work, discourse theory and ethnomethodology to analyse his interviews with family placement social workers. Finally, Carolyn Taylor (2008) stated that she used ethnomethodology and literary criticism to explore writing practices in social work. While there may be similarities between some of these approaches to analysis, there are also some major differences which may make combining them problematic. Indeed, Garfinkel and Wieder (1992 p.175) explicated the fundamental difference between EM and 'classic' sociology and described the two as 'incommensurable, asymmetrically alternate technologies'. Furthermore, the policy of ethnomethodological indifference is 'an indifference to the policies and methods of formal analysis...It is a procedure of not *needing* to consult the corpus of classic methods and findings' (Garfinkel 2002 p.170). Thus, by using a formal method such as discourse analysis or the conceptual work of Goffman, the authors are not applying EM indifference to the process of analysis.

The remaining two articles exclusively used ethnomethodology. The stated aim of the article by Maritta Törrönen (2006) was to analyse what community means in the framework of social network for young residents of a children's home. Again, the interaction between the young people (clients/residents) and the contacts between young people and adults (personnel/ staff) were not displayed in the article. In addition, Törrönen (2006 p.131) explained that she used the computer program Atlas.ti to code the data and to identify themes based on the ideas of grounded theory. The findings are presented as themes and the extracts used to support the theme are in the form of field notes which do not contain details of the interaction.

The final article where EM was used exclusively was by Jenni-Mari Rasanen (2011). Rasanen (2011) examined emergency social workers' interview accounts on case recording in IT-based case files: how they described case recording as part of their work and how they explained, justified and made sense of it in the interview situation. The analysis focused on such instances in interviews where social workers described what kind of case records they should produce and what are the criteria of good case recording: namely, the 'norm talk' of good case recording, this being the interviewees' descriptions of shared and normal ways of doing case records and of complying with them. Rasanen (2011) provided detailed extracts from the interview data in which the interview as an interactional accomplishment was kept intact. For example, Rasanen (2011 p.13) demonstrated how the interviewer 'strengthens the worker's response':

1 I: (. . .) So the recording, is it based more on facts then?

2 E: Yes, because you can't actually put in anything but facts, except assessments [then,

3 I: [Yes

4 E: that has to be clearly, it must be seen, that I as a social worker (I: mm) assess

5 or a question like this occurred to me or something made me consider or something, but

6 yes, facts and what you might call reflection mustn't get mixed together.

7 I: Oh yes, quite, that's true, yes (5) oh yes (1.5). (Rasanen 2011 p.13)

Here the part played by the interviewer in accomplishing the interview as an interaction is clearly shown. For example, the interviewer's question is included (line 1) and the extract shows how the interviewer provided very strong affirmative acknowledgment tokens (line 7). The article by Rasanen (2011 p.13) can be viewed as an exemplar of the use of ethnomethodology in social work research.

### **5.3.3 Assessment criteria for the articles using conversation analysis**

The articles where conversation analysis was used will be judged on the criterion of a concern with conversational orderliness.

In line with CA, the articles were all concerned with conversational orderliness. All of these articles were of a high standard in terms of their use of CA. An exemplar will be briefly discussed to illustrate the quality of the work.

The article by Heinz Messmer and Sarah Hitzler (2011) explored the process of 'declientification' in care planning conferences held to terminate the provision of long-term residential care to young people. The authors defined 'declientification' as the disestablishment of the identity of service user. This is accomplished through a range of interactional strategies to re-establish the young person as a 'mature and self-reliant citizen'. Messmer and Hitzler used very fine grained CA analysis to show the subtle rhetoric involved in the process of declientification. The professionals used rhetorical upgrading (concerning the positive development made by the young person) and rhetorical downgrading (concerning the need for further support) to create a picture of the young person as mature and self-reliant. Messmer and Hitzler (2011) showed how interactional asymmetries are removed by a noticeably informal stance of negotiation. The professionals work to reduce the gap between the actual and target living conditions with negative categorisations by the young person replaced by positive formulations and by referring to larger time distances in order to make the clients' personal progresses appear more distinct. Messmer and Hitzler (2011) concluded:

CA's perspective is indispensable if one aims to describe the hidden rationalities of everyday institutional practice. It can unveil the unquestioningly accepted constructions used by professionals and... make evident the contradictions and ambivalences that govern child welfare provision in the context on the termination of residential care (Messmer and Hitzler 2011 p.795)

The article by Messmer and Hitzler (2011) clearly demonstrated the value of conversation analysis for social work research and practice.

Three of the articles (White 2002; Broadhurst 2007; Hitzler 2011) specifically used Sacks' work on membership categorisation analysis (MCA). In his lecture in the spring of 1966, Sacks (1992 Part 1 p.236) used the first two sentences from a story told by a two year old girl in the book, *Children Tell Stories*, 'The baby cried. The mommy picked it up', to illustrate what he called the concept of the 'membership categorization device' (1992 Part 1 p.238). Sacks showed how the 'baby' and the 'mommy' are two membership categories that go together to form a standard relational pair and belong to the wider membership categorization device of the 'family'. These categories contain moral and normative inferences. For example, if the 'mommy' did not pick the baby up when it cried, it could be inferred that she was a 'bad mother'. The relevance of this example to the work of social workers is immediately apparent. One of the three articles that claimed to use MCA will now be examined.

The article by White (2002) used MCA to examine case formulations in an interprofessional child health setting. It is concerned with how professionals order clusters of symptoms and troubles into a recognisable case. It is interesting that this article by White (2002) was chosen as an exemplar of *narrative* inquiry by Riessman and Quinney (2005) in their critical review of narrative research in social work, particularly as White does not make any reference to narrative research. In a footnote, White (2002 p.433n) noted that there is an ongoing debate within ethnomethodology and conversation analysis about the status of membership categorization analysis and explained that 'I do not intend to go into that here,

where I have used MCA pragmatically, but hopefully fruitfully'. In this article, White (2002) skilfully showed how members of the team accomplish particular classifications of cases. She examined what she called 'not just medical' cases in which the most complex rhetorical work takes place. These are cases where the child does have an identified and named 'medical' problem but where this medical problem is seen as being exacerbated by parenting practices. For example, in the first extract involving the case of 'Sarah', White (2002) demonstrated how the consultant engages in accomplishing Sarah's mother as having features associated with a diagnosis of Munchausen Syndrome by Proxy.

Here, the consultant invokes his status as eye witness 'I have observed the following . . .' and the account is linguistically coded as fact not opinion – 'the mother concentrates on the medicalization of all Sarah's care'... Use of ironicisation such as 'she went on about' and accounts of the mother's questions about the consultant's expertise serve to signal that this mother is a 'troublesome patient by proxy'. (White 2002 p.422)

White (2002) methodically analysed the data so that the reader is clearly able to see the complex rhetorical work that the interprofessional team undertake in order to accomplish a particular formulation of a case. As such, this is an excellent use of Membership Categorisation Analysis.

## **5.4 Conclusion to the overview**

To conclude, this scoping review has provided an overview of the use of ethnomethodology and conversation analysis in social work research. Overall, the use of ethnomethodology was disappointing. The policies fundamental to ethnomethodological research such as ethnomethodological indifference and unique adequacy were not used or, in many cases, even mentioned. However, arguably it is very difficult to undertake a truly ethnomethodological study. Specifically, it is challenging to present the findings of a project without being able to elucidate and situate the study by importing classical findings from other work.



Conversely, the use of conversation analysis by the authors included in the review was excellent and clearly demonstrated the value of this approach to social work research and to social work practice. The detailed examination of an interaction that is produced through the use of conversation analysis allows for a richer understanding of how it is that social 'work' is accomplished.

It was notable that none of the studies included in the review were concerned with mental health social work. Thus, my study seeks to sit alongside other ethnomethodological and conversation analytical focused investigations of social work identity and occupational practices and to extend this knowledge to include mental health social work.

## 6 Social work identity within the interview interaction

### 6.1 Introduction

The focus of this chapter is to examine in more depth some of the matters introduced in the methodology chapter. In particular, the focus of the chapter is an exploration of how social work identity was accomplished *within the interview interaction*. I have explained how Harold Garfinkel's ideas provided initial insights into my interview data. Here, some of Garfinkel's work will be discussed in more detail, particularly in relation to my being a member of the social work group. The connection between being a member and the unique adequacy requirement of methods will be explored, alongside the emotional impact of doing research as a member. Another way membership was accomplished within the interviews was through the use of humour and laughter and this use of non-seriousness will be examined. In the final part of the chapter, the emphasis will shift to using ethnomethodology and conversation analysis to explore matters pertaining to doing interviews. In particular, the focus will be on how the interaction is accomplished *as a research interview*.

### 6.2 Being a member and the unique adequacy requirement of methods

There are two forms of unique adequacy: the 'weak' and the 'strong use', as discussed earlier in the methodology chapter. To recap, in the 'weak' use, the researcher must become a 'vulgarly competent' member (Garfinkel 2002 p.175). Thus, to study social workers, a researcher would need to become vulgarly competent in social work. This is identical to the ethnographer becoming a marginal native in order to study some group or culture. It is in the 'strong' use of unique adequacy that ethnomethodology goes one step further than ethnographic studies. In ethnomethodological research, the researcher maintains ethnomethodological indifference and thus should not make any judgement on the adequacy, value or

importance of the interaction (Garfinkel and Sacks 1970 p.166). Furthermore, the 'classic methods' of professional sociology are not necessary as the focus of the research is solely on members' methods (Garfinkel 2002 p.170). Unique adequacy is fundamental to ethnomethodology. Garfinkel specified that:

It is Ethnomethodological about EM studies that they show for ordinary society's substantive events, in material contents, just and only in any actual case, that and just how vulgarly competent members concert their activities to produce and show, exhibit, make observably the case, demonstrate, etc., coherence, cogency, analysis, detail, structure, consistency, order, meaning, mistakes, errors, coincidence, facticity, reason, methods – locally, reflexively, naturally accountable phenomena – in and as of the haecceities of their ordinary lives together. (Garfinkel 2002 p.191)

This focus *exclusively* on the developing interaction between members is at the core of ethnomethodological research. The members of an interaction are concerned with making their actions 'accountable', recognisable for the action it is. For example, that they are doing 'being ironic' rather than 'being serious'. Accountability is closely linked with 'reflexivity'. This does not have the same meaning as in many social work textbooks. For Garfinkel (1967 p.8), reflexivity refers to the constituent features of the settings that are made observable. In this way, 'actions do not merely communicate information to others... they always accomplish something socially' (Dennis et al. 2013 p.52).

Unlike a researcher who has to become uniquely adequate in the weak sense prior to or during the research process, as a social work member with over ten years post-qualifying experience, I was already vulgarly competent. Rather than spending time meeting this unique adequacy requirement, I naturally accomplished doing being a social worker in the research interviews. Indeed, during the fieldwork stage, this was so natural that the accomplishment was unconscious. Thus, when I thought that I was undertaking narrative interviews, in actuality the interviews can be seen as 'an ongoing accomplishment of the concerted activities of daily life, with the ordinary, artful ways of that accomplishment being by members known, used, and taken for

granted' (Garfinkel 1967 p.vii). This made a profound impact on the research. Being a member or more accurately, being oblivious to the ethnomethodological implications of being a member, means that I am fundamentally part of the data. Researchers enter into their ethnomethodological studies *as a researcher*. While they may learn and/or observe, they always have the social and intellectual 'distance' described by Hammersley and Atkinson (2007 p.90) earlier; the space where the analytic work of the ethnographer is achieved. Of course, the danger here was that I might not be able to achieve this 'distance'. It has certainly been the case that, at times, I did struggle on a both practical and emotional level during the research process. Having a non-social work supervisor for the final year of my doctorate, which happily coincided with the writing of the thesis, has been invaluable in creating distance from the unseen elements of being a member. For example, when writing about AMHP work, initially I did not make any attempt to clarify being on AMHP duty from the more general social work role of the AMHP. I implicitly assumed that this was 'obvious'.

Being a member has also had an emotional impact. On one occasion when writing this thesis, I reacted when writing about what two of the participants had told me. I was writing about social workers having to prioritise bureaucratic demands over the needs of the service user. I wrote:

This is a complete reversal of one of the core values of social work, empowering service users, and providing a needs-led service (NHS and Community Care Act 1990). This means that the focus of work is on the needs of the computer and not on the needs of the service user. It is a shocking indictment of social work practice.

Fortunately (if somewhat embarrassingly for me), my non-social work supervisor was quick to pick up on what he called 'bleeding heart hyperbole' and ask 'what happened to EM indifference on this page?'. The analytic distance had disappeared and my views had become enmeshed with those expressed by the participant. I was unable to maintain ethnomethodological indifference in terms of abstaining from

judging the adequacy and value of what the interviewees told me. Being a member also led to the feeling of having a 'dirty secret' which was discussed earlier in the methodology chapter. It also led to a feeling of 'transgressing the official line'.

### **6.3 Dirty secrets and transgressing the official line**

At the beginning of his thesis, Pithouse (1984 p.2) described how a journalist spending the day with one of the social workers in the children and families team was provided with a 'stage managed and fictional replay of daily work'. In contrast, as an observer immersed in the setting, Pithouse positioned himself as accessing real, invisible-to-the-journalist, social work practice. Interestingly, Pithouse was at pains to point out that although he had trained as a social worker, he had never practiced and now considered himself a sociologist:

I explained in detail that since social work training I had pursued an interest in sociology and considered myself attached to this career and not one in welfare. I emphasised my lack of experience in the job stating that I wished to be seen as knowledgeable but essentially inexperienced. I was not a practitioner. (Pithouse 1984 p.26)

In ethnomethodological terms, through undertaking this ethnography, Pithouse met the unique adequacy requirement in its weak sense (Garfinkel 2002). Pithouse (1984 p.39) explained that 'it is possible that the observer will receive the 'official' point of view until welcomed into the confidential world of the membership'. He cites Manning (1966)

...the 'line', 'fiction' or 'apologia' especially characteristic of the professions, is one of the most durable barriers to obtaining information about occupational and professional systems. During the first weeks I often received the 'line'. (Manning 1966 p.307)

In contrast, as a group member, I was able to move past this official line throughout the interviews. For example, the AMHPs told me atrocity stories; these are not told to 'outsiders' as will be explained below. In the preamble before the tape recorder

was turned on and the interview 'officially started, all of the AMHPs asked me about my background as a social worker. They asked where I had worked, where I had trained, and whether I had been an Approved Social Worker. I recognise now that this was a means of them establishing that I was a bona fide member. Another example of being a member was the use of humour; at some points in the interviews, the AMHPs presented social work in an ironic or humorous way. Eva, for example, stated that:

Eva: We're trained that empowerment thing is, you know, empowerment with the hand in the small of the back [laughs]

Lisa: [laughs]

I do not think that a social worker would describe a social work shibboleth such as 'empowerment' in this way to a social work 'outsider'. Telling me this can be seen as demonstrating that Eva recognises me as a group member. Rather than taking the 'official line' here social work is presented in a negative light. I feel guilty revealing such critical remarks in this thesis. For me, being vulgarly competent goes beyond a methodological requirement. It has a strong moral component interconnected with the feeling of having a dirty secret discussed in the last chapter. I feel like I am somehow transgressing the official line. It is this transgression that leads to the feeling of having a dirty secret. Being a social work member is a double edged sword in relation to the line: I am able to step over the line but revealing what I find there is deeply uncomfortable. This is encapsulated by Everett Hughes:

That people can and do keep a silence about things whose open discussion would threaten the group's conception of itself, and hence its solidarity, is common knowledge...To break such a silence is considered an attack against the group; a sort of treason, if it be a member of the group who breaks the silence. (Hughes 1971 p.91)

Thinking about this further, the thought of other social workers reading these tales from social work is fine. I imagine that they will laugh with recognition or identify with some of the more difficult situations. It is the thought of non-social work

outsiders reading this work that engenders the feeling of being 'dirty'. I feel ashamed and guilty and that I am betraying my cultural colleagues. These feelings are a demonstration that I remain a social work group member despite not being a practitioner. I have not moved into a new researcher identity, or not completely. Instead, I exist at the margins. For example, recently I attended an initial placement meeting in a Local Authority department and at the same time as being very much able to take part in the social work talk, at the same time I could 'see' the talk was replete with rhetorical devices. White (1997 p.328) described this as being 'meta' to oneself. What does this mean for my research? I am aware that it means that I might have 'blind spots' where I am unable to move beyond the 'natural attitude' described by Schutz (1945). Having a non-social work supervisor for the writing of this thesis has undoubtedly helped with this as he is able to see what I cannot see. However, this is not an issue for me in terms of believing that this work must present the 'final version'. As stated earlier, the aim is to contribute to a continuing dialogue with an external audience as part of a general commitment to fallibilistic, open-minded debate (Seale 2007).

Equally, being a member did have a positive impact on the research. In terms of the strong form of unique adequacy, I did not need to consult textbooks, reports or dictionaries to understand the use of specialised social work vocabulary which was key to the accomplishment of the interview interaction 'just and only in any actual case' (Garfinkel 2002 p.191).

#### **6.4 The use of specialised vocabulary in institutional talk**

Being a vulgarly competent member (Garfinkel 2002 p.175) enabled me to understand the specialised vocabulary involved in doing being a social worker. Achieving unique adequacy is a necessity in understanding practices that have specialised populations (Rawls 2002 p.6). Once again, when the interviews occurred, I was not aware that we were using words, terms or acronyms that only a competent member would understand. However, it is now clear to me how endemic

these were to our talk. Numerous instances of this specialist vocabulary can be found throughout the thesis, whenever the interview talk is subject to analysis. However, a few brief examples from the interviews can now be given as illustrations of how being uniquely adequate was imperative to the on-going accomplishment of the interview as interaction. The first example is from the interview with Rose:

1 Lisa: And when you were on the training with the psychologist were you  
2 there with your health colleagues?

3 Rose: Yes there were some nurses not doctors there were some of the  
4 staff from the hospital from the ward the PICU yeah.

Here Rose is referring to the psychiatric intensive care unit, a specialist ward for people requiring an enhanced level of support. The next example is from the interview with Grace:

Grace: When I hear it's a 136 I don't mind. I drop down there.

An Approved Mental Health Professional is required to have a very good knowledge of the Mental Health Act and this is a key component of AMHP training. Thus Grace and I both have this members' knowledge that she is referring to section 136 of the Act which is concerned with 'Mentally disordered persons found in public places'. Under this section, a police officer can remove a person 'who appears to him [sic] to be suffering from mental disorder and to be in immediate need of care or control' to a place of safety. The person can then be detained in the place of safety for up to 72 hours so that s/he can be examined by a registered medical practitioner and to be interviewed by an AMHP so that any necessary arrangements for his or her treatment or care can be made. Thus, Grace is talking about receiving a referral to interview someone who has been detained on section 136. This example serves to illustrate the extensive knowledge that is required to understand such a short statement.



The third example is from the interview with Eva. Eva was talking about her first position as a social worker after qualification.

Eva: I remember filling out my first risk assessment and my first CPA.

Here Eva is referring to completing two forms: a risk assessment form and a care plan under the Care Programme Approach (CPA). Being uniquely adequate means that I recognise that these forms are crucial and a fundamental requirement in mental health social work. All service users must have an up to date risk assessment and a CPA care plan. Having members' knowledge means that we are both aware that the Care Programme Approach was introduced in 1990 and set out the following requirements for people receiving mental health services: a systematic assessment of their health and social care needs; the formulation of a care plan to address their identified health and social care needs; a named care co-ordinator to coordinate the care plan; and regular reviews to ensure that the care plan still meets the needs of the service user. The CPA was revised in 'Refocusing the Care Programme Approach: Policy and Positive Practice Guidance' (Department of Health 2008) and now focuses on people in contact with secondary mental health services who have 'complex characteristics'. These 'characteristics' are set out in a table in the 2008 Guidance. Again, the purpose of this long description of the history of the CPA is to demonstrate that being a member means that - unlike a social work outsider - I already have this knowledge.

The final example of the use of specialised vocabulary is from the interview with Ben:

- 1 Lisa: And what about CTOs? How do you find those, about working with
- 2 those as obviously social workers were concerned about the
- 3 introduction?
  
- 4 Ben: [laughs] I'm going now to see someone who has been recalled
  
- 5 Lisa: [laughs] oh right!

6 Ben: [sigh] I think when they came in the figures vastly exceeded  
7 estimates and when they first came in I think then we just used them for  
8 people on section three it was felt that we should be looking at CTOs. I  
9 think that they were over used. I think then tribunals started taking  
10 people off and there was a reduction in number.

Here I am referring to Community Treatment Orders (CTOs) which were introduced by the Mental Health Act 2007. Social workers were part of a coalition, the Mental Health Alliance, which campaigned against the introduction of CTOs. Ben replied to my question by stating that he is going to see someone who has been 'recalled' (line 4). A person subject to a CTO can be recalled to hospital under section 17E of the Mental Health Act 2007. In his reply Ben also mentions 'section three' of the Mental Health Act which is the power to detain someone in hospital for treatment for up to 6 months (line 8). Finally, Ben refers to a 'tribunal' (line 9); this is a Mental Health Tribunal. The purpose of a Mental Health Tribunal panel is to review the cases of people detained under the Mental Health Act and to direct discharge where the statutory criteria for detention are not met. The panel comprises a judge and two members, one of which will be a medical specialist.

To conclude, the purpose of these examples has been to demonstrate that it is an essential requirement that any researcher is able to understand and use specialist vocabulary in order to 'recognise, or identify, or follow the development of, or describe phenomena of order in local production of coherent detail' (Garfinkel 2002 p.175). In her introduction to Garfinkel's book, *Ethnomethodology's Program*, Anne Warfield Rawls explained that:

When the subject of research is something that most persons participate in regularly...then unique adequacy can be assumed for most persons...However, with regard to practices that have specialized populations...unique adequacy can be very hard to achieve. An Ethnomethodologist pursuing unique adequacy within a specialized population may spend years in a research site becoming a competent participant in its practices. (Rawls 2002 p.6-7)

My competence as a participant had been achieved before the research project; being a member enabled me to recognise, identify, follow and describe the specialist talk. The use of these terms, abbreviations and acronyms demonstrates that Rose, Grace, Eva and Ben recognise me as a group member.

Being a group member also played a part in the accomplishment of humour and laughter within the interviews which has been briefly touched on at various points throughout the thesis. The amount of laughter and humour in the interviews was striking and it seemed important to analyse the part this was playing in the interaction. Thus, the next section explores this issue in more depth.

## **6.5 Doing non-seriousness**

During the transcription process I noticed that there was a great deal of humour and laughter within the interviews. These were not straightforward jokes or quips but tended to be what White (2006 p.35) has described as 'gallows humour'. In particular, White identified that the use of humour and storytelling in interprofessional and multi-agency work 'often take the form of ironic banter about "the other"' (White 2006 p.31). Pithouse (1998 p.87) also found that the children and families social workers had 'a certain bleak humour that only those engaged in this business can fully appreciate'. This section of the thesis will examine some examples of humour and laughter within the interviews. Following Liz Holt (2013), the focus will be on the more general category of 'non-seriousness'. This category includes humour, laughter, hyperbole, irony, and non-literalness. Holt stresses the importance of the sequential; participants negotiate and collaborate in producing non-seriousness over a series of turns. The section will conclude with a discussion of two examples where there was some sort of breach in doing non-seriousness. This section uses a modified form of the transcription conventions developed by Gail Jefferson which began when she was transcribing some of the recordings that Sacks' used in his lectures. Jefferson (1985 p.25) explained that the issue is not transcription per se, but 'what it is we might want to transcribe, that is, attend to'.

For Jefferson, the crucial point is that the focus on detailed observation of actual events and transcription is one way of achieving this. As Sacks (1995 Part 2 p.419) pointed out, instead of using what he called ‘hypotheticalized, proposedly typicalized’ versions of the world as a basis for study, researchers should use a ‘close looking’ at the world. For Sacks (1995 Part 2 p.420) from ‘close looking at the world we can find things that we couldn’t, by imagination, assert were there...interesting things that as yet unknown’. Thus, the detailed transcription conventions developed by Jefferson (1984) are an attempt to realise this close looking at the world. I wish to attend to the laughter in the interaction and so this has been transcribed in more detail in this section. The key to the Jeffersonian transcription symbols is contained in Appendix five.

### 6.5.1 Gallows and bleak humour

The most obvious indicator of non-seriousness in interaction is laughter (Holt 2013). All of the interviews contained laughter; either following a first part pair (Sacks 1992) or during more extended sections of talk. This subsection will begin by presenting some examples of short exchanges and then move on to analyse some more extended exchanges. As White (2006) noted, many of these are about ‘the other’, usually a nurse or the more generic ‘health’. Grace, for example, stated that:

- 1 Grace: I pu:sh a social work perspective (0.4).hh even thou:gh, (0.4)
- 2 health wants me to be:: (0.6) a sort of (0.8) professional
- 3 eunuch (0.4) .t [°ha:h° .hh] hu::h
- 4 Lisa: [°Hu::::h° ] Ha
- 5 Grace: With its, (.) you kno::w
- 6 Lisa: .hhhh
- 7 Grace: (0.4) “you’ve got to do thi:s, you’ve got to do th:at”
- 8 Lisa: Mm-
- 9 Grace: Okay, (0.4) we use a social work perspective.

Here Grace is contrasting actively promoting the social work perspective with the more prescriptive medical model. The description ‘professional eunuch’ (line 2) implies that ‘health’ would like social work to play a powerless and ineffectual role within the mental health team. Buttny (1997) has discussed the use of reported speech by ‘prototypical’ group members:

Perhaps the most interesting way to summarize a group is through a quote of the prototypical group member. This resource allows the reporting speaker to *epitomize* the group through their characteristic utterances. (Buttny 1997 p.499)

Here Grace is using active voicing to characterise ‘health’ as authoritarian and prescriptive: “‘*you’ve got to do thi:s, you’ve got to do th:at*’”. Grace’s laughter (line 3) is a ‘laughable’; an invitation to laughter. By laughing at the end of her turn, Grace is displaying that she is not being serious, making laughter an appropriate response (Holt 2013 p.109). Indeed, I respond by laughing. At the end of this exchange, Grace once again returns to serious talk, reiterating the point she made in the first line.

In another short exchange, I laugh at the end of Ben’s turn, despite him not laughing at this point in the interaction.

- 1 Ben: But I: recently, (0.4) got asked to review some- to assess  
2 somebody (.) who’s had three CTOs already. A:nd obviously it’s  
3 not working
- 4 Lisa: ↑No:: °hu::h°
- 5 Ben: [£you get the idea £ (.) it’s
- 6 Lisa: [huh ↑.hhh hu:h .hh
- 7 Lisa: £Yeah£
- 8 Ben: [↑huh this is pointless putting this person on a CT[O let’s=
- 9 Lisa: [huh .hhh huh .hhh [yea::h,
- 10 Ben: = try and work with him in other ways real[ly.

11 Lisa: [Yeah

In this example, the 'laughable' is Ben's ironic statement ['A:nd obviously it's not working'] coupled with a deadpan delivery. The understanding of this statement requires unique adequacy or competency. Specifically, it requires the knowledge that a Community Treatment Order (CTO) is revoked by the Responsible Clinician as set out in Section 17F (4) of the Mental Health Act 2007. When a CTO is revoked, the authority for detention in hospital takes effect as if the person had never been discharged from hospital on the CTO. Thus, a person 'who's had three CTOs already' (line 2) has been recalled to hospital and had the CTO revoked three times. Ben uses a smile voice (Holt 2013) as he continues his reply, confirming that he is being non-serious (line 5). My laughter shows my understanding of his sarcastic and ironic phrase 'you get the idea that it's pointless putting this person on a CTO' (line 8). This short story positions the psychiatrists as being oblivious that placing this service user on a CTO is 'pointless' and that this medical form of intervention should be replaced with a wider response. That this 'proper' response comes from a social work perspective is signalled by the phrase 'let's try to work with him in other ways' (line 10). Here the use of 'let's' is a collective term and the term 'to work with' is endemic in social work talk and reflects the view that the social worker and service user work in partnership. In the coda to the story, Ben has returned to serious talk and my understanding of this turn is shown by my acknowledgment token (line 10-11).

This idea that unique adequacy is necessary to understand the non-seriousness will be explored further towards the end of this section. An extended episode of non-seriousness will now be examined. This more extended sequence of non-serious talk comes from the interview with Ed. Ed has been talking about training to become an AMHP, specifically about a 'difficult period' when he was convinced that he had failed the law exam.

1 Ed: I always have this good wa::y (.) good thing that whenever I  
2 ha::ve (.) difficult periods (0.4) which you ↑must try:: £ri(h)ght£

3 Lisa: Huh ha

4 Ed: If you ever have a difficult period as a social worker ↑go on the  
5 GSCC si::te, (.) and look at cases pending,

6 Lisa: Oh yeah, [I ↑have been on that,] ↑yeah [yeah]

7 Ed: [Hu:::h (.) .hh huh huh ha ha .hh] [it's] ju::s[t hu:h]  
8 (.) beyond belief [isn't it, because it's]=

9 Lisa: [yeah, ha ha] [ye::s ye::s ]

10 Ed: =li::ke, (.) .hh it's sort of like (0.4) "*well if I'm fucking u:p right,*  
11 (0.4) ↑read ↑thi::s",

12 Lisa: Yea:[:h

13 Ed: [£kno(h)w what I mea::n£

14 Lisa: Yeah, [You would never go there [with what they're ↑doi::ng,

15 Ed: [↑↑l:::t >sort of<  
16 [amazing stu::ff >you know< so there was a bit of that going=

17 Lisa: [↓Yeah (0.4)

18 Ed: =on [during the cou::rse

19 Lisa: ↑Huh huh [£ye::s£ (oo:::h) lovely

20 Ed: [£You know£ when I was £struggling£ a bit

21 Ed: I'd say [*oh lets just look at what's going on in £the=*

22 Lisa: [Hu:::h

23 Ed: =↑G[SCC (.) cases pending"

24 Lisa: [£↑Yea:::h

25 Lisa: ↑Yea:h

26 Ed: ↑↑"O:::h", (0.4) you know (0.6) ↑"drunk ↑dri↑vi:ng (0.4) father  
27 three £ki::(h)ds" you [know what I mea::n you're li:ke,

28 Lisa: [Yeah

- 29 Ed: "I'm oka::y" (.) £yo(h)u kno(h)w£ huh huh [hu::h
- 30 Lisa: [Yeah (0.4) "I am trying my be::st",
- 31 Ed: Yeah ↑huh ↑huh
- 32 Lisa: "I am quite ethically [£sou:nd" ye(h)a:(h):h£
- 33 Ed: [Yea::h yea::h
- 34 Ed: ↓I mean "I'm nowhere nea:r (.) this lea::[gue"
- 35 Lisa: [No
- 36 Ed: ↑bu:t, (0.4) I'm (.) you ↑know but all joking aside ↑↑it ↑↑is
- 37 diffi[cult (.) when you haven't got that suppo::rt you [know?
- 38 Lisa: [Mm [yes,
- 39 Lisa ↑Yeah.

Rather than being about 'the other' as in health professionals, here Ed's is talking about social workers. In the first line, Ed moves fluidly from being serious to being non-serious, signalled by the use of a 'smile voice' (Holt 2013). Recognising this shift, I laugh (line 3). Ed then talks about a way of coping with difficult periods by looking at the Fitness to Practice case hearings on the General Social Care Council (GSCC) website. The GSCC was the regulatory body for registered social workers at the time of the interviews (now the Health and Care Professions Council). The website contained details of the hearings held when social workers had been accused of misconduct. Ed uses irony and a smile voice during this interaction. We both use active voicing to co-narrate the story. What is notable here is that I present my statements *as if I had made them at the time* that Ed is telling me about ["*I am trying my best*" and "*I am quite ethically sound*"]. Of course, I had never met Ed before and so these statements had never actually been made. This is another example of where active voicing is a more accurate description than reported speech. The exchange works to mock, ridicule and parody the prototypical social worker on the GSCC website (Buttny 1997). Laughter is interspersed throughout.



However, we are not laughing at a 'real' social worker; indeed our laughter accomplishes our disaffiliation with this unethical social worker. At the same time, the laughter and co-narration accomplishes our affiliation as bona fide members. Holt (2013) contended that an extended sequence of non-serious talk such as this is relatively unusual in interaction.

Finally, this section of the interview talk concludes with a return to non-seriousness, explicitly accomplished with the words 'But all joking aside' (line 17). Here Ed is 'formulating'; namely, he is 'saying-in-so-many-words-what we-are-doing' (Garfinkel and Sacks 1970 p.171). Garfinkel and Sacks (1970 p.170) saw formulating as one way of remedying the 'obstinately unavoidable and irremediable' nature of indexical expressions. Thus, this sequence of non-seriousness is sandwiched between serious talk.

These examples from Grace, Ben and Ed have shown how gallows and bleak humour are accomplished within the interviews. What is apparent, particularly in the excerpts from Ben and Ed, is that unique adequacy or vulgar competency is necessary in order to accomplish and understand this non-seriousness. This will be explored in more depth in the next section.

### **6.5.2 Non-seriousness and unique adequacy**

When I was undertaking the interviews, I did not realise that the laughter, irony, sarcasm and hyperbole was a joint accomplishment. Rather, it felt completely 'natural' and mundane. Analytical distance has allowed for the accomplishment as 'work' to be made exhibitable, observable and reportable (Garfinkel and Sacks 1970). It was my competency as a social work member that allowed me to accomplish the non-seriousness within the interviews. It is also my competency that allows me to understand the non-seriousness as an analyst. Furthermore, in being '*vulgarily* competent' (Garfinkel 2002 p.175) I am able to understand the specialised vocabulary, institutional talk and indexical expressions in both the on-going practical

accomplishment of the interview interaction and in analysis without recourse to a dictionary or a textbook. This section will examine four more examples of non-seriousness which clearly demonstrate necessity for the unique adequacy requirement to be met. The first excerpt comes from the interview with Rose. Rose has been talking about some of the difficulties when undertaking Mental Health Act assessments; in particular, doctors' lack of legal knowledge of the use of section two and section three. I ask:

- 1 Lisa: Because even in the co::de doesn't it say actually nowada::ys  
 2 that, (.) didn't the code change and say almost like you had to  
 3 put people on a two more or le::ss in that, it could have  
 4 cha::nged?
- 5 Rose: Exactly that's the commo:n (.) now, I think what people say is  
 6 (1.0) ↑because, (0.6) obviously if (0.4) the person's been  
 7 admitted if they're not well (.) then the treatment plan needs  
 8 (0.6) asse- er assessment doesn't it,
- 9 Lisa: ↑Yes [yes-
- 10 Rose: [So, (0.4) hence they should be on a two, whatever. E:r-  
 11 (0.6) and treatment plan is not just "o::h (0.6) *ten milligrams of*  
 12 what [*olanzapi:ne*" which they seem to think=
- 13 Rose: Lisa: [°hu- (.) huh huh°
- 14 Rose: =oh ↑that's enou::gh. (0.4) .hh yeah "*we know this person we'll*  
 15 *put them on a three*". So I think it's importa- you know to stand  
 16 your ground as a social worker and not [0.8] they will if they  
 17 can get their own way they will=
- 18 Lisa: .hhhh huh huh
- 19 Rose: =£try:£ huh huh huh.

Once again, this extract contains both serious and non-serious talk. Unique adequacy or vulgar competency is required to understand specialised vocabulary such as 'the code' (line 1) 'on a two' (line 3), and 'olanzapine' (line 12). The 'code' is (sadly) not a social work equivalent of Wieder's (1974) 'convict code'. Rather, Rose is

referring to the Code of Practice: Mental Health Act 1983 (Department of Health 2008), the production of which is a requirement of section 118 of the Mental Health Act. A person suffering from a 'mental disorder' can only be detained if they meet strict criteria which are set out in the Act. The detention can either be under section two or three of the Act. Section two is admission for assessment and lasts for up to 28 days; section three is admission for treatment and lasts for up to 6 months (and can be renewed). The Code makes it clear that treatment can be given if the admission is under 'section two' and it is this that Rose argues that the doctors do not understand. There is a section of the Code titled 'Section 2 or section 3' which specifically deals with this issue: point 4.26 states that Section 2 should be used if:

- the full extent of the nature and degree of a patient's condition is unclear;
- there is a need to carry out an initial in-patient assessment in order to formulate a treatment plan, or to reach a judgement about whether the patient will accept treatment on a voluntary basis following admission; or
- there is a need to carry out a new in-patient assessment in order to re-formulate a treatment plan, or to reach a judgement about whether the patient will accept treatment on a voluntary basis.

This is what Rose is referring to in the interview when she states that 'obviously if the person's been admitted if they're not well then the treatment plan needs assessment doesn't it? So hence they should be on a two' (lines 6-8 and 10). Rose uses active voicing to demonstrate the doctors' lack of this legal knowledge [*'Yeah we know this person we'll put them on a three'*]. She also uses active voicing and sarcasm to parody the narrow focus of the doctors on medicine – 'olanzapine' is an anti-psychotic drug used to treat schizophrenia or bipolar disorder - and the medical model as the only form of treatment [*'and treatment plan is not just "oh ten milligrams of olanzapine" which they seem to think that's enough'*]. This use of active voicing accomplishes the doctors as inadequate, misguided and somewhat clueless. Rose ends her reply with the coda that it is important for a social worker to

be assertive during Mental Health Act assessments in order to counter this incompetence [‘if they can get their own way they will try’]. Again, our shared laughter at the end of this exchange displays affiliation.

Indexicality also plays a crucial part in non-seriousness. Indexicality points to the ‘essential incompleteness’ of language (Garfinkel 1967 p.29); the ‘transient circumstances of its use assure it a definiteness of sense...to *someone who knows how to hear it*’ (Garfinkel and Sacks 1970 p.161 italics mine). Specifically, I know how to ‘hear’ the non-serious talk due to our shared group membership. Indexicality is displayed in the following two short extracts from the interviews with Frank and Olivia. The first extract is from the interview with Frank. Frank is has been talking about his experience of AMHP training.

- 1 Frank: I ↑really loved i:t, I mean found the (.) the |a::w (.) quite  
2 difficu:lt certain aspects of i::t. U:::m, (.) ↑are you::? ↑w- were  
3 you:?  
4 Lisa I was, [ha ha ha ha  
5 Frank: [huh huh huh huh

Frank is asking whether I am currently an Approved Mental Health Professional [‘Are you?’] or whether I have been an Approved Social Worker (ASW) as signified by the past tense [‘were you’] as this role no longer exists. I reply that ‘I was’ an ASW. However, this does not need to be elaborated in the interaction. This is an example of ‘glossing practices’ whereby a speaker ‘in the situated particulars of speech mean differently than they can say in just so many words’ (Garfinkel and Sacks 1970 p.164). For Garfinkel and Sacks (1970 p.164) in ‘endless, but particular, analyzable ways glossing practices are methods for producing observable and reportable understanding’. Here the exchange culminates in shared laughter displaying our co-orientation and alignment (Glenn 2003). It is notable that in both of the last two extracts that the shared laughter occurred at the end of the topic. Holt (2010) showed how shared laughter is often associated with topic termination and that

shared laughter can contribute towards the 'bounding-off' (Schegloff and Sacks, 1973) of a topic.

The next extract from the interview with Olivia is also about AMHP training. Olivia has been talking about how much she enjoyed the training.

- 1 Olivia: It was ↑brilliant (.) ↑and I: and I liked being able to piece  
2 together lots of stuff and I loved learning the la::w (0.4) like I  
3 just loved it [huh ha I was just really into it
- 4 Lisa: [Ha ha ha ha
- 5 Olivia: .hhh [u::m
- 6 Lisa [Do you still have jo::nes?
- 7 Olivia Yea::h (.) [yea::h we've still got ↑jones [(0.4) ↑love (.)=
- 8 Lisa: [huh hu::h [hhh hu
- 9 Olivia: =love Jones
- 10 Lisa: ha::h ha

Here the word 'jones' refers to the book *The Mental Health Act Manual* by Richard Jones. It is the key text used both on AMHP training courses and in AMHP work. The extended shared laughter throughout this exchange appears to mark what Glenn (2003 p.84) calls 'an episode of celebration in talk' as we recognise each other as group members. Shared laughter also displayed affiliation between the members of the group interview. Here Isobel is talking about the importance of supervision for maintaining a social work identity.

- 1 Isobel I >↑↑think certainly supervision because I supervise care  
2 management staff (.) a::nd specialist social worke- and it is a  
3 different ↑ball ga:me. It's mo::re (0.4) intense on the case type  
4 super↑vision (.) like to supervise an assessment officer it might  
5 take me (1.0) up to two hours (0.6) ↑wi:::th ↑with an AMHP  
6 (.) it will be three hours and I still haven't ↑finished because it's  
7 all the complexity o:f, [The people bits

- 8 John: [£I don't get that long£,
- 9 Isobel: ↑Don't you [oh ha ha ha ha ha
- 10 Karen: [Huh huh huh huh .hh huh huh
- 11 John: [Ha ha ha ha ha ha
- 12 Tim: Huh huh huh
- 13 Isobel: I ↑speak for myself then
- 14 Tim: Yeah
- 15 John: [Huh huh huh huh
- 16 Karen: [Ha ha ha ha
- 17 Isobel: ↑Ha ha ha ha ha
- 18 Tim I'll come to you then
- 19 John: Huh huh
- 20 Karen They'll be queuing up to (.) .hh huh.

At the start of this extract, Isobel uses a contrast structure to show the complexity of AMHP work compared to that of 'normal' case supervision of care management staff and specialist social workers. Isobel describes supervision with AMHPs as a 'different ball game (line 3), 'more intense' (line 3), requiring a great deal of time because of the 'complexity' of the work (line 7). Isobel is 'doing being serious' throughout this part of the talk. However, John interjects with a humorous denial of this, delivered with a smile voice (line 8). From this point in the interaction Isobel, John, Tim and Karen collaborate in accomplishing humorous banter.

This section has explored the necessity of unique adequacy to accomplishing non-seriousness. The next section examines White's (2006) finding that the use of humour in interprofessional and multi-agency settings often takes the form of ironic banter about 'the other'.

### 6.5.3 Ironic banter about the other

White's (2006) assertion that social workers engage in ironic banter about the other is interesting when applied to my interviews. As I am a 'bona fide' member, such banter can be found in the interview as interaction. Two examples of this banter will be explored in this section.

The first example is taken from the interview with Ed. Ed has been talking about the possibility that a generic mental health qualification will be introduced in the future. I ask for clarification about whether he sees this as being based on the medical or the social model.

- 1 Ed: ↑This is an interesting question isn't it? (0.4) ↑social workers  
2 get a ba:d ↑press Don't they and, (0.6) ↑if they were to  
3 promote as a (0.6) a (1.8) a social mode:l, now could you see  
4 that going do::wn (.) very well (0.6) as a PR exer£ci(h)se£
- 5 Lisa: ↑No, (0.6) no
- 6 Ed: It ↑wouldn't rea[lly] would i::t you know because you know it  
7 the ↑social model conjures u::p, (1.8) you know (0.6) Baby ↑P  
8 ↑That's what it conjures u::p, All these social workers walking  
9 i:n and the child's covered in chocolate and thinking ↑ "*oh it's*  
10 *alri:ght*", (.) you know (0.6) "*they just want to live the way they*  
11 *wanna li::ve*" and you kno::w ↑that's what it c- conjures up  
12 this ↑whole scenario doesn't it and unfortunately that's the  
13 (0.6) climate we ↑live i:n so they'll never promote tha:t
- 14 Lisa: No (0.6) And do you think nurses still got a good press?
- 15 Ed Yeah well they do:: don't they? (0.4) .hh ↑nu::rses >I mean<  
16 I'm being very kind of e::r, (0.4) playing devil's advocate here a  
17 little bit but, (0.6) ↑nurses, (.) it's always (0.4) £Great Ormond  
18 Street ho(h)spital£ [isn't it huh
- 19 Lisa: [(£Yeah£)
- 20 Ed: £You kno::w,£
- 21 Lisa The opposite of baby P

- 22 Ed: Nurses and you know the::y're overwo::rked
- 23 Lisa Ange::ls
- 24 Ed [↑Angels.

Ed begins by making the point that social work is presented negatively by the media and that this means that promoting the social model would not be well-received. Although he uses a smile voice (line 5), I do not view this as a laughable; rather I recognise this as a serious topic which has been highlighted in the Final Report of the Social Work Taskforce (2009). Ed continues by using bleak, gallows humour to describe this view of social work [‘the social model conjures up you know Baby P that’s what it conjures up]. Agreeing with this, I ask Ed if he thinks that nurses are still seen positively by the media. Acknowledging that he is ‘playing devil’s advocate here a little bit’ (line 16-17), Ed portrays nurses as associated with Great Ormond Street Children’s hospital (line 17-18). Here then are two contrasting sides of professional interaction with children: a child that is killed after abuse and poorly children in hospital. This time we both laugh as the banter has now shifted to the non-serious. Finally, the banter is completed with a co-narrated coda.

Another example of ironic banter occurred in my interview with Andrew. I have asked Andrew to describe the members of his CMHT. Andrew begins with a serious reply to my question, talking about how occupational therapists (OTs) do not have a voice and therefore are left out of the ‘debate’ (line 1-2 below).

- 1 Andrew: unfortunately, they kind of get left out of  
2 [the debate a little bit
- 3 Lisa: [Mm:::
- 4 Andrew: I’m not sure whether they ↑like that really I’ve, (.) you know  
5 ↑ou- our OT is (0.4) .hh ↑they always seem to be very quiet  
6 O[Ts to me
- 7 Lisa: [Huh huh ↑£ye(h)::s£ .hh



- 8 Andrew: They seem to be from, (.) e::r they seem to be different  
 9 ↑people I mean all the nurses on my team are all just really  
 10 lou::d and, (0.6) obnoxious [most of the time
- 11 Lisa: [Ha ha ha
- 12 Andrew: And the social workers are a little bit like that but a bit more  
 13 lofty and snobby,
- 14 Lisa: Hu::h ha [↑ha ↑ha
- 15 Andrew: [And the OTs just never say anything,
- 16 Lisa: A:::h [huh
- 17 Andrew: [You know and .hh huh huh
- 18 Lisa: That's a sha::me, (.) so 'cause they obviously can take up the  
 19 AMPH role, [ca::n't they?
- 20 Andrew: [They can yea::h, I think the think that'd be a  
 21 very, (.) .hh I think the chances of that happening are [pretty  
 22 slim
- 23 Lisa: [Hu:::h ↑ha,
- 24 Andrew: I've spoken to quite a few OTs and >they said< they wouldn't  
 25 touch it with a barge [pole

At the end of Andrew's first reply, there is a subtle shift from seriousness to non-seriousness ['they always seem to be very quiet, OTs to me']. I laugh with recognition, establishing that we are 'cultural colleagues' (Garfinkel 1967 p.11). This is followed by a sequence of Andrew satirising nurses, social workers and OTs punctuated by my laughter. Andrew marks the end of this sequence by laughing (line 17). Indeed, it is noticeable that this is the first time he has laughed in this exchange. Instead, it has been Andrew's satire, irony and dead-pan delivery that has achieved the non-seriousness. I respond to his invitation by laughing and continuing the banter with a somewhat sarcastic comment ['Ahhh that's a shame'] before asking a more serious question (line 18-19). Andrew provides a serious answer before immediately returning to the banter ['They can yeah, I think the think that'd

be a very (.) .hh I think the chances of that happening are pretty slim’]. Again, this extended sequence of banter confirms White’s (2006) findings. The next section will examine the notion of ‘troubles talk’.

#### 6.5.4 Laughter and troubles talk

There were numerous occasions within the interview interactions where the AMHPs talked about their ‘troubles’ and it was noticeable that laughter was often present in these tellings. The notion of ‘troubles talk’ was developed by Gail Jefferson, as mentioned earlier in the section on the rubbish and the treasured. To recap, Jefferson (1984) found that although people may laugh when telling their troubles, the other party in the interaction does not treat this as a laughable so does not laugh but instead produces a recognisably serious response. Some examples from the interview data will now be examined in detail.

In this extract from the interview with Nell, she is explaining the pressures of being employed by the Local Authority and seconded to the Health Trust.

- 1        Nell:        One ↑minute I’m a local authority employee:: and the next  
2                    minute ↑I:::’m (.) >you know< working in a health trust tea:::m,  
3                    I mean my ↑training sometimes I fee::l, (0.8) absolutely  
4                    exasperated with i::t, (0.4) there’s com↑pulsory, (0.4) training  
5                    that at the trust we have to do::: (0.4) and then the:re’s  
6                    training obviously I have to do as an AMHP, (0.4) in order to  
7                    keep my:: (.) war- my u::m (0.6) regi- social worker in order to  
8                    keep my registration, And then there’s my ↑AMHP update (.)  
9                    mental health upda::tes, (0.6) ↑and ↑sometimes th- the ↑two  
10                    things are the ↑↑sa::me and >I’m thinking well ↑↑why am I  
11                    doing it ↑↑twi:ce? Why am I doing Mental Health ↑A::ct  
12                    update with the local authority and ↑the:::n, (0.4) as trust (0.4)  
13                    they’ve got training on mental ↑hea::lth, they’ve got training  
14                    o::n (0.4) .hh on u::m, (0.8) ↓o::h what is it the ne:w one (.)  
15                    with people that a::re,
- 16        Lisa:            Capacity (.) [Mental capacity: Act

- 17 Nell: [Capacity hhh (.) ↑°you kno::w ↑ “why am I doing  
 18 it *twi:ce?*” ↑ “*O:h it shows on our statistics*” cos the team  
 19 have to be:, (0.4) a ↑↑↑hundred per cent up to date with  
 20 ↑their [↑training, (.) so: the trust don’t wanna give in wanna  
 21 give in thei::r, (.) statistics, (0.4) .hh hu::h .hh (0.4) £and ↓  
 22 h(h)ave to be on the statisti::cs£ Although I’m not em↑ployed  
 23 by the::m, (0.4) and so if I don’t do i::t, i- it reflects badly on the  
 24 team because they haven’t got one hundred per cent training  
 25 (0.6) up to date and then they, a:::::h I ↑was ↑thinking ↑when  
 26 do I do any wo::rk? ↑huh ↑ha huh I’m doing £training for the  
 27 trust£, (0.4) training for the local authority, (0.4) £raining as an  
 28 AMHP£ When do I ↑↑actually do any wo::rk? Huh huh ↑ha ↑ha  
 29 ↑ha ↑ha
- 30 Lisa: [So you really a:::re
- 31 struggli::ng (?) (?) ↑you ↑a:::::re,
- 32 Nell: [between a rock and a hard place
- 33 Lisa: ↑You ↑a::re (0.4) ↑you ↑a::re.

Nell begins her reply with an ‘abstract’ (Labov and Waletzky 1967) – ‘one minute’ she is a Local Authority employee and ‘the next’ she is a member of the team in the Health Trust (line 1-2). Nell then illustrated this point with a narrative about the training that she is required to do. She explained that she has compulsory training to do as a member of the Health Trust (line 4-5) and additionally, as a social worker, she has to undertake continuing professional development in order to remain registered with the Health and Care Professions Council (line 7-8). Finally, Nell needs to remain up to date with mental health legislation, including case law, in order to practice legally when undertaking AMHP duty (line 8-9). My unique adequacy is displayed when, in an aside, Nell asks ‘oh what is it the new one with people who are?’ and I immediately recognise this as a reference to the Mental Capacity Act 2005 (lines 22-24). The use of active voicing adds to the dramaturgical depiction of the situation (line 17-18).

Even though Nell tells the story in a humorous manner using a smile voice (lines 33 and 40) and laughs several times during the course of the telling (lines 21, 32, 39), I

do not laugh at any point during her narrative. Indeed, even though Nell ends the story by laughing at length (line 45), I do not join in. Instead, recognising this as troubles talk, I acknowledge how difficult managing these dual pressures must be ['you really are struggling']. The coda to the narrative is co-narrated. I begin by stating 'you are' and Nell completes the sentence 'between a rock and a hard place'. It is interesting here to consider the work of Harvey Sacks on stories, doing 'understanding' and proverbial expressions. For Sacks (1992 vol. 2 p.427), stories are puzzles and it is the listener's job to understand them. The place for the 'understanding' of stories is at the directly on the completion of the story (1992 vol. 2 p.425). In addition, Sacks showed how proverbial expressions are a particular type of utterance used to do 'understanding'. For Sacks, then:

Examining the distribution in conversation of proverbial expressions, one characteristic place they occur is on story completions. And one characteristic use of them is as understandings of the stories they are produced directly after. (Sacks 1992 vol. 2 p.422)

This claim made by Sacks is evident here: the proverb is used at the completion of the story and artfully accomplishes understanding of the story. Thus, this is a clear example which demonstrates Jefferson's (1984 p.350) findings that 'the troubles-recipient declines to laugh by talking to the prior utterance and thus by talking to the trouble'.

In a second example of troubles talk, although Andrew is talking about his troubles, I do respond by laughing. In the extract, I have asked Andrew about his experience of detaining one of the service users on his caseload under the Mental Health Act.

1        Andrew: He's a very complex case and he's a very difficult man .hh (0.6)  
 2            e::r with a lot of difficult issue::s (0.4) so I was I was worried,  
 3            [e:r] (.) about it And I think that, (.) if he gets unwell again (0.6)  
 4            hopefully he won't (0.4) um ↑I won't be the one that's been, (.)  
 5            that won't be doing it if ↑I'm expected to work with him in the  
 6            longer te::rm [↑I wouldn't be::, (0.8) I wouldn't be detaining  
 7            him I wouldn't be I I ↑wouldn't be assessing him under the  
 8            Mental Health Act=

- 9 Lisa: [Right okay
- 10 Andrew: =again.
- 11 Lisa: Is that (.) can you choose not to can you::? (0.4) if you::
- 12 Andrew: Well ↑not really, £you can re↑fu:se not to£ huh huh huh
- 13 Lisa [£Yeah£ huh
- 14 Andrew: >Well I mean< can't even do that: [bu:t I probab- (0.4) I  
15 would argue (0.4) vociferously that um it was inappropriate for  
16 me to do that
- 17 Lisa: Oka::y (0.4) >and you [(still) feel that that would  
18 be accepted [acceptable
- 19 Andrew [£It might do£
- 20 Lisa: £↑Yeah£ huh huh huh [.hhhhhhh yeah
- 21 Andrew: [We'll have to wait and see [huh huh huh

At the beginning of his reply, Andrew talked about being 'worried' about detaining one of the people on his caseload (line 2). He described this service user as a 'very complex case', a very difficult man' with 'a lot of difficult issues' (line 1-2). Thus, the service user is depicted in a way which makes being 'worried' seem like an understandable response. Next Andrew states that he will not be the one to assess this service user again under the Mental Health Act if he is 'expected to work with him in the longer term' (line 5-8). I reply with a question ['Can you choose not to, can you?'] because in my social work experience it is seen as good practice that AMHPs undertake assessments of their own service users because of the knowledge they have of that person. Andrew acknowledges this and mirrors my phrase ['You can refuse not to'] and laughs (line 16). While this is arguably troubles talk, I do laugh. However, it was noticeable that Andrew had also used a 'smile voice' (Holt 2013) and so I treat his laughter as a 'laughable', an invitation to laugh. The example shows how subtly serious talk about 'troubles' can shift to non-serious talk. Thus, as Andrew did not laugh at the end of the talk about the service user at line 10, my next (serious) question appears to have marked the end of the talk about troubles.

In other words, the serious talk has been completed and a shift to non-serious talk is now possible. Therefore, Andrew's reply at line 12 initiated the humorous exchange.

After the banter, Andrew then shifts back to serious talk (line 14). He states that he would 'argue vociferously' that it would be inappropriate for him to undertake the assessment (line 15) and my reply is also serious. However, in the final exchange, Andrew once again uses a smile voice and laughter (line 25) and I again respond by laughing. In this extract the talk has moved fluidly between doing being serious and doing being non-serious talk. It is an example of Holt's (2013) findings that it is not possible to provide a clear cut distinction between seriousness and non-seriousness:

...it is not always even appropriate to see them as two sides of the same coin; rather, in interaction they are regularly so closely intertwined as to be frequently inseparable. (Holt 2013 p.107)

Thus far this discussion has focused on examples where the accomplishment of non-seriousness (and seriousness) in the interviews has been successful. However, there were two occasions in the interviews where this was not the case. These incidences will now be examined.

### **6.5.5 Where humour goes wrong**

During transcription, I noticed that there were two points in the interviews where there seemed to be some sort of 'breach' in the production or negotiation of non-seriousness. As in Garfinkel's breaching experiments, such breaches can 'produce reflections through which the strangeness of an obstinately familiar world can be detected' (Garfinkel 1967 p.38). These occurred in the interviews with Andrew and John and will be analysed in this section.

The first breach occurred in my very first interview. Andrew had been talking about the first Community Mental Health team he worked in where there was a distinct 'split' between the social workers and the nurses (below):

Andrew: Although they were an integrated integration team umm [pause] it was very much split between there was the social workers and the nurses, ok, and the social workers social worked and nurses nursed ok and never the twain shall meet.

In an interesting dichotomy, Andrew depicts the team as ‘was very much split’ even though the team was ‘integrated’ (a health and social care term for an interprofessional team). Again, it is nurses that are presented as the ‘other’. The extent of the division between the two professions is portrayed through the phrase *‘the social workers social worked and nurses nursed ok and never the twain shall meet’*. Here Andrew’s use of the archaic word ‘twain’ resembles the language of a fable, emphasising the antiquity of the gulf.

Andrew continued the reply by reiterating the word ‘split’ thus emphasising the point even further (line 1 below).

- 1 Andrew: There really was a split a::[n,  
2 Lisa: [Right  
3 Andrew: You know an- >an- an- an-< the nurses we:::re (.) of a certain  
4 a:ge of- often they were more e::r i::n (.) i:n their late fifties  
5 (0.6) .hhh a:nd (.) they we:re ↑used to working in a very::, (0.4)  
6 more tra↑ditional way of nursing And the:y (.) they had a very  
7 very fixed identity (0.4) .hhh so we used to have this thing  
8 where th- the (0.4) student nurses used to come in and some  
9 of them (.) >you know< (.) used to say (0.6) °what do social  
10 workers do?°  
11 Lisa: Right oka:y  
12 Andrew: You know I always used >to have this< stock li::ne I used to say  
13 (0.4) well .tch nurses nu::rse (0.4) social workers do (0.4)  
14 °>everything else<°  
15 Lisa: Ha ha ha ↑ha:::h  
16 Andrew: You know  
17 Lisa: Huh huh [£Y(h)ea(h)h£ ha ha

- 18 Andrew: [A:nd u::::m, (0.4) and (.) >I mean< that's how it was
- 19 Lisa: Right
- 20 Andrew: U::::m, (0.4) ↑an::d, (.) it was (0.4) °ah° the bumping of two  
 21 bureaucracies (.) really I found it fascin[ating I really do I [laugh  
 22 at it (.) a lot of the ti[:me
- 23 Lisa: [Yea::h yea::h

Andrew begins his reply by portraying the nurses as outdated through the combination of the words 'traditional', 'of a certain age' and 'late fifties'. In addition, Andrew describes the nurses as having 'a very very fixed identity' (line 6-7) which uses an 'extreme case formulation' (Pomerantz 1986) to imply rigidity and a narrow focus. Andrew then goes on to depict student nurses as asking the question '*what do social workers do?*' (line 9-10). It is interesting to note that it is students that are depicted as asking this question. As discussed earlier, students are somewhat naïve and can be seen as 'marginal natives'. They have not developed a complete understanding, and so have the privilege of being able to ask such questions. It is also notable that it is a student nurse that is depicted as asking this question. Arguably, a social work student should know the answer to the question as part of becoming a social worker. Andrew uses active voicing to dramatise his answer: "*well nurses nurse and social workers do everything else*". This 'stock line' achieves many things. Firstly, the 'fixed identity' of the nurses is directly contrasted with social workers who 'do everything else' (line 14). The phrase also portrays nurses as being able to boundary their work and therefore have a clear role. In contrast, the social workers lack role clarity. Finally, the social workers are described as filling in the gaps left between what the nurses will do. These themes echo those discussed earlier in Chapter 4. Here my laughter (line 15 and 17) exhibits my understanding and recognition of this story. The use of active voicing and the deadpan delivery of this pithy aphorism is an example of the straightforward use of being non-serious. The coda 'and that's how it was' reinforces the truth claims of the story (line 18).



In the final part of his reply (from line 24 onwards) Andrew depicts the two professions as jarring ['it was the bumping of two bureaucracies']. Thus nursing and social work are portrayed as completely separate entities 'bumping' into each other in the CMHT. Through the use of the phrase 'really I found it fascinating I really do' (line 21) Andrew seems to be presenting himself as able to stand back and look at the situation objectively without any emotional impact on him as an individual in the team. This contributes to the 'authorisation' of this version of events (Smith 1978). In the final line of the reply Andrew states that 'I laugh at it a lot of the time' (line 21-22). However it is notable that he is not laughing and nor am I. Liz Holt (personal communication, April 15, 2013) described this as an 'interesting phenomenon'. Holt suggested that:

...it seems that he's using 'laughing at it' as a way of formulating a kind of attitude (that we might gloss as something like - finding the situation ridiculous but not letting it get to him)... It may also be used to suggest that he doesn't take things too seriously. (personal communication, April 15, 2013)

Again, this can be seen as an example of the 'inextricable interdependence of seriousness and non-seriousness' (Holt 2013 p.105).

The other apparent breach in the use of non-seriousness occurred in the interview with John. John is discussing the referral process to the Community Mental Health team by the AMHPs who remain separate from this team. Here John is describing the difficulties the AMHPs have in referring service users to the Community Mental Health team (CMHT). He tells an atrocity story and which again positions a nurse as other.

John: But umm if we refer anyone now it's got to go through the [name] team and so the [name] team sends out a CPN who doesn't look at social care in the same way as us "*oh no – he's not appropriate for our team*" they don't see the preventative and what we've got is CMHTs who'll only deal with crises but when it's a crisis it's "*oh no it's too much for us – he needs to go somewhere else*".



20 John: Yes, yeah I feel it is

Thus, John is doing seriousness in the first part of the extract (line 1-5). My reply, 'But not if they're in too much of a crisis' (line 9), is a direct allusion to John's earlier statement [*"oh no it's too much for us – he needs to go somewhere else"*]. This ironic comment can be seen as a 'laughable', inviting laughter. However, John does not laugh (line 8). Instead, he replies in a somewhat disfluent way ['Well yeah Because'] followed by a pause. Thus, John does not responding to my laughter but continues doing being serious. Next, John describes another 'argument' which reiterates the earlier story: namely, that the CMHT do not accept the referrals of the social workers as the service users are either not "*poorly enough*" or "*too poorly*" (lines 9-14). By continuing in this serious vein, John is perhaps making it clear that it is not a laughing manner and so my laughable was not appropriate. Again, there is a disfluent response ['Yes so'] to my somewhat flippant quip 'Either way' (line 20). Finally, John makes it clear that he is being serious with his statement that 'I find it very sad' (line 21). Understanding the seriousness of the talk at last, I respond with sympathy ['So that's a resource that you've lost']. At the time, my understanding was that John was being non-serious and so I responded as such. However, analysing the interaction in retrospect, it is apparent that John was being serious throughout. What I interpreted as irony was meant as a scathing indictment of the CMHT. I was unable to distinguish that John was using sarcasm in the sense of being derisory, rather than in being mocking. Again, this example demonstrates the inextricable interdependence of seriousness and non-seriousness.

To conclude, this section of the thesis has explored the use of non-seriousness in the interview interactions. It has built upon the work of Holt (2013), Jefferson (1984), White (2006), and Pithouse (1998). It has also shown that the ethnomethodological concepts of unique adequacy and indexicality play an important part in accomplishing non-seriousness. The focus of this chapter so far has been on the impact that being a member had on the interview as interaction. Now the focus will shift slightly to examine the ways that the interaction is managed *as a research interview*.

## 6.6 Doing interviews

The final part of the Chapter is concerned with the ways the interaction is produced and managed *as a research interview*. Again, the work of ethnomethodology and conversation analysis is used to concentrate on the 'haecceities, the just thisness' (Garfinkel and Wieder 1992 p.203) of the interview encounter. In his very first lecture in the Fall of 1964, Sacks advised researchers:

Just try to come to terms with how it is that the thing comes off...just let the materials fall as they may. Look to see how it is that persons go about producing what they do produce. (Sacks 1992 Vol. 2 p.11)

The focus of the next section is to examine a number of ways in which the interaction 'comes off' as a research interview through 'a close and detailed examination of the in situ collaborative work in and through which actual interviews are produced' (Hester and Francis (1994 p.689).

The work of Carolyn Baker, introduced in the methodology chapter, is relevant here. Baker (2003 p.399) pointed out that interviewees are interviewed as members of some specific category which the interviewer has assigned them. Thus, I am specifically interviewing my participants as social workers. The focus of my questions are about being a social worker so other potential identities, such as being a mother, a lesbian, or a widow, will not be addressed unless specifically mentioned by the social worker themselves. Mazeland and ten Have (1996) described this as the inevitable tension between what they call the 'life world story' and the more narrow interests of the researcher. In addition, each participant was aware that they are being interviewed as a social worker and so the onus was on them to speak as a competent member (Baker 2003) and a moral practitioner (White 1997). The participants in the group interview were co-members of the social category 'social workers' (ten Have 2004 p.71).

Research interviews can be seen as one form of 'institutional interaction'. Drew and Heritage (1992 p.4) explained that interaction is institutional 'insofar as participants'

institutional or professional identities are somehow made relevant'. Thus, a meeting between a social worker and a service user is one form of institutional interaction, as is a ward round or case conference. The interview as interaction is 'characteristically asymmetrical' (Drew and Heritage 1992 p.47). In my research, although we were both social workers, the different research identities – interviewer and interviewee – that we assumed during the interview had an impact on the interaction. As such, these are not 'just ordinary conversations among members of this community' (Schegloff 1998 p.415). The agenda has been set by me. I have already decided that the interview will be a 'narrative interview'. In an attempt to enable the social workers to complete a narrative arc from the beginning of their social work story to the future, the first question was to ask when the person first thought about becoming a social worker and the last question asked how they saw the future of mental health social work. However, before this 'official' talk commenced, as signalled by pressing play on the digital recorder, talk 'outside' the interview interaction had already taken place. This talk was also asymmetrical but in a directly contrasting way; it was the social workers who asked me the questions. They asked where I'd done my social work training; where I had worked; how long I'd been a practitioner; and why had I decided to do the PhD. This can be seen as them seeking to establish my credibility for interviewing them by checking that I was a 'bona-fide' member of the social work group.

All the interviews started with my asking the same question, albeit sometimes slightly worded differently, about when the interviewee first became interested in becoming a social worker. This question related to the choice of methodology that I was using at the time of the interviews: namely, the dialogical narrative approach (Mishler 1999; Riessman 2008). I wanted to generate narratives within the interviews so my opening question was to ask the interviewee to tell me about the beginning of their social work 'story'; how they first became interested in becoming a social worker. In conversation analytic terms, I wanted to generate what Mazeland (1992) described as 'discourse unit interviews'. Mazeland (1992 quoted in ten Have 2004) contrasted 'turn-by-turn' interviews (which mainly consist of short speaking

turns) with 'discourse unit' interviews. In the latter, the interviewee is seen as the expert and so is the primary speaker and the role of the interviewer is to actively support the talk. ten Have (2004 p.64) showed how the interviewer provides a set of overall and specific instructions as to how the interviewee should tell their story and what should be included. Thus, by asking the interviewees to start with the beginning of their story, they have been asked to provide a chronologically ordered series of events which necessarily requires a longer reply. Thus I was actively asking the interviewee to engage in a longer turn. Another way of generating a longer reply was to ask the social workers to provide an example:

Nell: Umm so yeah that was the main thing that I found a bit conflicting at times

Lisa: Can you tell me or give an example of something?

This was made explicit in the interview with John where he asks me if I want him to tell a story about 'fights with consultants' [psychiatrists].

John: I mean I've been in many, many fights with consultants who say "*this person needs to be in hospital*" and I say "*no they don't*". Umm I can give you an example if you want one?

Lisa: Yes please give me an example.

Once given permission, John told a long story without any interruptions from me (see section 8.3.3.1).

Questions can be seen as the first part of what Sacks named an 'adjacency pair'. In his first lecture in Spring 1972, Sacks identified a small number of features that characterise adjacency pairs. Adjacency pairs are 'two utterances long, adjacently placed, have various names, a relative ordering of parts, and a discriminative relationship for the parts' (Sacks 1992 p.527). Sacks showed how adjacency pairs are found in greetings, closings, and in questions-and-answer exchanges. Examples of the straightforward question-and-answer adjacency pair was found in the interviews with Olivia and Frank:

Lisa: So my first question is sort of a similar starting point which is - what was it that first interested you in becoming a social worker?

Olivia: I think I was actually destined to be a social worker really [laughs].

Lisa: So can we start at the beginning with you and that is how did you first become interested in social work yourself?

Frank: I've always been interested in social work from the moment I knew what it was.

My question has invited a particular kind of response which Olivia and Frank give without hesitation or qualification. Here 'becoming a social worker' is implicitly bound with 'inherent vocation'. These answers can be seen as the 'preferred' response to the question (Pomerantz 1984). Such responses are given without hesitation.

In contrast, deviations from this 'preferred' response are 'delayed, qualified and accounted for' (Hutchby and Wooffitt 1998 p.45). For example, Paul's reply:

- 1 Lisa: The first question that I wanted to ask you is umm how did you first
- 2 become interested in social work?
- 3 Paul: Right ok it was not I'll tell you what it wasn't a so called traditional
- 4 vocational calling.

Paul's 'dispreferred' response is delayed and disfluent. Significantly, his reply also displays the implicit understanding of what would be a preferred response – a 'traditional vocational calling'. A 'dispreferred' response also occurred in the interview with Eva:

- 1 Lisa: How did you first when did you first become interested in becoming
- 2 a social worker?
- 3 Eva: It's not a great story really in terms of social work identity. I did I did
- 4 a degree in Psychology and originally I wanted to be an IAPT therapist.

Eva prefaces her answer by priming me that her answer does not relate to what she knows to be the purpose of the interview. Through her reading of the Information Sheet and the signing of the Consent form, in addition to the discussion we have had prior to the interview 'starting', Eva is aware that I am interested in the topic of

'social work identity'. Her answer shows that she is already framing the interview in terms of the category 'social work identity'. She is forewarning me that her 'story' does not fit into this category. Eva's reply that 'It's not a great story really in terms of social work identity' is interesting because her answer does reveal something about what a 'great story' or a story fitting neatly into that category would be. Her reply that she did not want to be a social worker but instead chose social work because it 'looked the easiest' route to becoming an IAPT [Improving Access to Psychological Therapies] therapist demonstrates that a 'proper' story would be to actively choose to become a social worker.

The final example of a first question adjacency pair is from the interview with Ben. Before the audio recorder had been turned on, Ben had been asking me about my social work biography. My first question is an attempt to move from this ordinary talk to institutional talk:

- 1 Lisa: But to start with, how did you first get into social work?
- 2 Ben: Oh [pause]
- 3 Lisa: What was it that attracted you?
- 4 Ben: I think it's like what you were saying before, you don't start off with  
5 a master plan do you really to become a social worker. Well, hopefully  
6 not anyway
- 7 Lisa: [laughs]
- 8 Ben: It would be quite worrying if you do. I graduated umm in 1992 and I  
9 didn't have a clue what I wanted to do.

This exchange is notable in several ways. Firstly, Ben does not answer the opening question but pauses and hesitates. This is a type of delay device that Pomerantz (1984 p.70) called 'no immediately forthcoming talk' and the lack of a second part to the adjacency pair is a 'noticeable absence' (Hutchby and Wooffitt 1998 p.42). I attempt to repair this disjuncture by re-framing the question (line 3). What is interesting is that Ben continues with the 'ordinary talk' by referring to our



conversation prior to the interview interaction (line 4). His two replies appear to suggest that it is not clear to him that the interview interaction has begun. It is only part way into his third reply that Ben finally provides the second part to the adjacency pair ['I graduated umm in 1992...']. It is not until this point that the interaction begins to 'come off' as a research interview.

There was another noteworthy disjuncture during the interview with Eva. Eva has been talking about how social workers tend to separate themselves from the rest of the Community Mental Health team:

1       Eva: just from over the years the different social workers it's easy for  
2       social workers to not be part of the team. There are have been social  
3       workers who are quite peripheral they keep themselves to themselves  
4       much more. Because they're so independent there can be an element of  
5       less team-working. I mean I'm not particularly like that and nor is one of  
6       the other social workers but one of our social workers sits and you very  
7       much never really know what he's doing and whereas it's funny so I will  
8       trust him what he's doing the nurses are very suspicious of him: "*he's*  
9       *always out on visits but look at his sheets*". There's a sort of distrust  
10       because I suppose their interventions take twenty minutes and we can  
11       have anything it can take weeks and weeks and weeks so there's some  
12       distrust I think.

Eva explains that other social workers have been 'quite peripheral' and independent' (line 3) and this results in an 'element of less team-working' (line 4-5). She provides an example about one of the social workers to illustrate the point: whereas she trusts that the social worker is doing social work, the nurses are 'very suspicious of him' (line 8). This connects with Pithouse's depiction of social work as an invisible trade due to the invisibility of encounters with service users and the invisibility of the outcomes of these unobserved events (Pithouse 1998 p.11). However, Eva states that she is 'not particularly like that' (line 5). The next exchange is interesting. I 'think aloud', trying to make sense of this apparent anomaly: why is Eva not like the other, 'properly invisible' social worker?

- 1 Lisa: But you're [pause] different from that. I wonder if that's because  
2 you've always worked in integrated teams. Would you say that social  
3 worker has been qualified a long time?
- 4 Eva: Not much more than me I don't think
- 5 Lisa: Oh really
- 6 [10 second pause]
- 7 Eva: I don't know. I don't know why it is really. It could be a personality  
8 thing. I've certainly worked on teams where I've not really liked the  
9 people that I've sat with and I kept myself to myself. Umm because I like  
10 that I've always said "*do I need to do this?*" whereas as the other social  
11 workers they never ever talk about what they're doing there's less they  
12 don't joint work umm they feel they very much they're doing it on their  
13 own I think umm and that makes the rest of the team feel excluded I  
14 suppose and then they react to that. [pause] umm and yeah I don't know  
15 but yeah I just don't. I mean I probably it's funny with the nurses they  
16 are the ones who talk to each other about their cases the most I think.  
17 But then they are very much used to working like that aren't they on  
18 wards and we are lone workers and it's about adapting to a team.

I try to explain this apparent anomaly by attributing it to the length of time that Eva has been qualified. This means that she has always worked in integrated teams and so has not experiencing working in a social work only team (line 2). However, this 'theory' is disproved because the other (real) social worker has been qualified for a similar amount of time as Eva (line 4). I am perplexed and do not ask another question so there is a long pause of 10 seconds (line 5-6). With hindsight I can see that this 'silence' belongs to me; I have not provided a comment or question that completes my turn. Presumably, Eva was waiting for me to speak. Rawls (2006 p.28) discussed how such 'incongruities present themselves as moments of confusion or ambiguity, and they can be produced only against a background of finely articulated expectations'. Finally, Eva does provide a repair, stating that it could be due to personality (line 7) and giving an example of where she did act like the other social worker (line 8-9). However, she then reiterates that she is different from other social workers [*I've always said "do I need to do this?"* whereas as the other social workers they never ever talk about what they're doing]. Eva then acknowledges that she is

more like a nurse in this respect [‘it’s funny with the nurses they are the ones who talk to each other about their cases the most I think’]. Significantly, the coda to the reply affirms the ‘natural attitude’ [‘we are lone workers and it’s about adapting to a team’].

During the interviews, there were several times where the interviewee explicitly made reference to being engaged in a research interview. For example, in the group interview, Tim joked:

- 1 Tim: through numbers yeah. Failure through numbers. That’d be a good  
2 name for your report
- 3 [all laugh]
- 4 Lisa: [laughs] Thank you. But that’s awful isn’t it because they are the  
5 mental health team.

Tim orientates the group to the interview situation by referring to my ‘report’ (line 2). Although I join in with the laughter, it is noticeable that I immediately attempt to re-orientate the discussion back to the narrative with the phrase ‘But that’s awful isn’t it’. The use of the word ‘But’ demonstrates that I am deviating from the ‘preferred response’ (Pomerantz 1984) by not making a sequential response to Tim’s statement. Here I am doing what could be glossed as ‘doing putting the interview back on track’. This can be seen as an example of the tension within the interview interaction (Mazeland and ten Have 1996). I wanted the group to keep to *my* agenda. This deviation occurred much more often in the group interview as multiple speakers meant I had less control over the talk of any individual social worker. Another way that I achieved ‘keeping to the agenda’ was by returning to the areas that interested me. For example, in the interview with Olivia:

- 1 Lisa: So again you felt like you developed your knowledge and your skills
- 2 Olivia: Well yeah. It’s all learning and it’s all good

- 3 Lisa: And how did you find that whole power thing that you were talking  
4 about before, the detention. Did you struggle with that?

Here I reiterate the key words that Olivia has used earlier in the interview [‘that whole power thing that you were talking about before, the detention’] which moves the talk back to an area that I wish to explore further. Repeating key words indicates the ‘locally contingent character’ of questions (ten Have 2004 p.67). In other words, the questions are indexical to the previously occurring talk.

However, that is not to say that the interviewees were passive participants in the interaction. They also returned to areas of the interview that had interested them. For example, in the group interview, Tim stated:

Tim: just going back to your question about identity

Here it is Tim that was setting the agenda for the talk; although in this case, it is firmly within my remit. The interviewees also asked me questions:

- 1 Lisa: And you’ve talked before that you don’t feel that the OTs and the  
2 nurses don’t have that kind of background so how do you think?
- 3 Ed: Possibly. What do you think?
- 4 Lisa: Well, that’s my research!
- 5 [both laugh]
- 6 Lisa: That’s what I’m interested in really.

Here the deviation from the institutional interaction (i.e. that questions are asked by the interviewer), is marked by my exclamation and the laughter. It is notable that I do not answer Ed’s question and bring the focus back by explicitly referring to my ‘research’. The interviewees also deviated from simply answering my questions by introducing new topics. For example, this occurred in the interview with Cath:

Lisa: And do you think that the AMHP role, or ASW as was, do you feel that that is a valued social work role?

Cath: For instance, I know it's slightly diverting but, you know the profile about adoption this week?

A similar exchange occurred in the interview with Ben:

Lisa: And do you think that it's important that social workers have those views?

Ben: Yes, definitely, definitely. I mean I think [pauses] jumping off but obviously you are getting people now who are coming starting social work education at eighteen.

That this was a deviation from the institutional interaction was always signalled in the talk. Here Cath acknowledges that she is 'slightly diverting' and Ben pauses before using the phrase 'jumping off'. This demonstrates that they both recognise that it is not the interviewee's role to introduce new topics which do not directly answer the interviewer's question or fit into the overall research focus. Again this is an example of the tension characteristic of research interviews (Mazeland and ten Have 1996). There were other points in the interviews when the social workers made a direct reference to being in a research interview. In the interview with Hal, for example:

- 1 Lisa: Yes – oh what time is it oh nearly
- 2 Hal: So you're doing this unscripted aren't you?
- 3 Lisa: I am yes. Although I have certain topics
- 4 Hal: Yes I can see that yeah yeah so it's very led by what comes up
- 5 Lisa: By what you say yeah [pause] umm so here the integration is
- 6 working quite successfully?

Here I am the first to move 'outside' the institutional interaction by making reference to the time. Hal had told me that he needed the interview to be finished by a certain time. Appearing to recognise this as 'time out' from the interview; Hal asks me a question about the way that I am 'doing the interview' (line 2). While I do answer, there is then a pause and delay (line 5) before I move back into the

institutional interaction by asking a relevant 'research' question ['so here the integration is working quite successfully?']. Another example of a shift outside the research interview occurred within the group interview. John is talking when Lucy enters the room:

- 1 John: which I think if we didn't have we'd struggle  
2 [door opens Lucy enters the room]  
3 Lucy: sorry  
4 Isobel: don't swear you're being recorded  
5 [all laugh]  
6 Lisa: Hi. I'm Lisa. I'm the researcher who emailed and I think John told  
7 you I was coming  
8 Lucy: yes  
9 John: we're just talking in general at the moment, well Lisa's asking sort  
10 of questions and we're talking in general. So we haven't said anything  
11 too bad  
12 Isobel: It's to do with the identity of social workers is what the remit's  
13 about and whether you maintain that better in as we are or whether it's  
14 better in an integrated mental health setting is the gist of it I think  
15 Lisa: Yes that's it. Thank you. So do you all feel strongly that you are  
16 social workers still?

Using humour, Isobel immediately alerts Lucy to the institutional interaction ['don't swear you're being recorded'] and also explains the 'remit' of my research to Lucy (line 12-13). Isobel is the manager of the team and so may have considered it her role to induct Lucy into the group interview. After thanking Isobel, I turn the talk back into 'research talk' with my question 'So do you all feel strongly that you are social workers still?' where the preface 'So' marks the change from ordinary to institutional talk.

Cath also moved 'outside' the research interview interaction:

1 Cath: I take pride in it really: that I value people treat them with respect.  
2 It's that honesty isn't it? That's also a big thing for me too [pause] I don't  
3 know what I'm giving you what you need [laughs]

4 Lisa: You are completely, you are completely

5 Cath: And I'm not sure really does it come from your upbringing? Is it  
6 something we try and incorporate? I don't know where it comes from.

Cath directly seeks reassurance that she is fulfilling the category of a competent social work interviewee ['I don't know what I'm giving you what you need']. Once this is confirmed, without any hesitation Cath immediately continues with the interaction as a research interview (line 5). The notion of temporality is significant here. This exchange occurred at the beginning of the interview with Cath. Ed asked a similar question to Cath:

1 Ed: I mean that's one of the things I like about the Mental Health Act as  
2 opposed to the Capacity Act is that it gives people their rights. There're  
3 safeguards in there. Are you getting enough?

4 Lisa: Oh what's the time? Yes it's excellent it's been a really interesting  
5 discussion

6 Ed: It's been really interesting for me too.

Although it may appear like Ed is asking for reassurance that he is being an adequate interviewee ['Are you getting enough?'], the temporal placement of the question - we have been talking for two hours - means that I immediately realise that he is indicating that he wishes the interview to finish. The asymmetrical relationship of the institutional interaction would suggest that it is always the interviewer who chooses when the interview interaction is to conclude. This exchange with Ed demonstrates that this can be more subtle; even though it is me that officially closes the interview, it is arguably Ed who has accomplished this closure. In contrast, some of the interviewees resisted my attempt to end the interview. For example, towards the end of the group interview Tim stated:

Tim: I know you're trying to bring it to an end but we've had interesting scenarios, haven't we?

Tim's action here led to the interview continuing for another twenty minutes. Again, this was more noticeable in the group interview. In an individual interview, I had more opportunity to control the talk because the role of 'speaker' alternated between us. In the group interview, there were long periods where I was not involved in the talk except as a listener.

The final question about the future of social work would always be followed by my asking the interviewee if they had anything that they wanted to add. Giving them the floor in this way is a 'sanctioned departure' (Peräkylä and Silverman 1991 p.634) from the institutional identities of interviewer and interviewee. The interview interaction ended once the interviewee had replied to this invitation. I would then turn the audio recorder off and the talk would then move from institutional to ordinary.

The aim of this section has been to demonstrate some of the ways in which the interaction has come off as a research interview. Insights from conversation analysis such as 'preferred' and 'dispreferred' responses, 'adjacency pairs' and 'disjunctures' have been used to display the subtle ways in which the asymmetrical relationship is artfully managed by both parties in the interaction. While the agenda was set by me from the very beginning in asking the interviewees to 'speak as a social worker', the social workers were also able to control some aspects of the interview, such as choosing the direction of the talk and moving 'outside' the interview. This was particularly apparent in the group interview. However, these occasions were always marked by an acknowledgement that this was a deviation from the business of doing a research interview.



## 6.7 Conclusion to chapter

This chapter has examined how social work identity was accomplished *within the interview interaction*. The chapter began with a discussion of the impact of sharing the same social work identity as my participants. The connection between being a member and the unique adequacy requirement of methods was explored. Unlike a non-social work researcher, as a member, I was already uniquely adequate in the weak sense. This played a huge part in the interaction as it meant that social work identity was accomplished during the research interview. For example, being a vulgarly competent member enabled me to not only understand but also to use *specialised vocabulary* within the interviews. However, doing research as a member had an emotional impact, specifically the feeling of having a dirty secret as a result of transgressing the official line. Another way that social work identity was accomplished within the interviews was through the use of non-seriousness. It was argued that unique adequacy was necessary to successfully accomplish non-seriousness. Laughter, irony and mimicry were all ways of accomplishing our affiliation as bona-fide members of the social work collectivity, as well as our disaffiliation with 'outsiders'. Interestingly, these 'outsiders' included other social workers. Here the use of non-seriousness was the means of displaying disaffiliation with these non-genuine social workers. Finally, building on the work of Holt (2013), the inextricable interdependence of seriousness and non-seriousness was demonstrated. This was particularly evident in the telling of troubles (Jefferson 1984).

In the final part of the chapter, ethnomethodology and conversation analysis were used to examine the ways in which the interaction was accomplished *as a research interview*. A detailed examination demonstrated the ways in which the talk moved between 'official' interview talk and unofficial talk 'outside' of the interview. Asked to 'speak as social workers', the interviewees implicitly recognised that the 'preferred' response to the question about becoming a social worker was to allude to a vocational calling. However, the interviewees were not merely passive

respondents and there were numerous deviations from the institutional business of doing a research interview. For example, the social workers asked me questions, shaped the direction of the subject matter, and co-accomplished the closure of the interview. Thus, the subtle ways in which the asymmetrical relationship is artfully managed by both parties in the research interview have been demonstrated in this chapter.

The final chapter in the thesis is concerned with another way in which social work identity was accomplished with the interview interaction – the telling of atrocity stories.

## 7 The use of atrocity stories

### 7.1 Introduction

One of the first things I noticed during the process of transcription was the extent of the use of stories within the interviews which depicted other members of the Community Mental Health team in a poor light compared to the social worker. All of the social workers told at least one such story. Most told many such stories within the interview. Here is an example from the interview with Eva [nb. this story is analysed below in section 8.3.2.1].

1       Eva: We will come into the job wanting to change people's lives. Nurses  
2       do not. They come in wanting to make people better. It's a different idea  
3       isn't it? And we're sort of trained in that non-medical thing. The idea of  
4       better to us doesn't mean the same thing, you know. We probably spent  
5       less time talking to people about their symptoms and that sort of thing.  
6       We look at different things. I mean we do, it is important but certainly  
7       not. I mean I've been out on assessments with nurses and who sit there  
8       and say to people "*so, do you hear voices? Are you thoughts racing?*" and  
9       the person is sitting there going "*no, no, no*" and you're sitting there  
10       thinking "*they're obviously mad aren't they?*" and the nurse comes away  
11       and goes "*well, they're fine*" and they're not are they? [laughs] But it's  
12       very [pause] you know. It's very medical. The guy was knocking his house  
13       down so it was obvious to me but the nurse didn't seem to notice that.

As described in Chapter 2 (see especially 2.14), at first these stories seemed completely 'normal'. However, repeated listening during transcription and reading the words written out on the page created a sort of 'distance' where I began to see that these stories had a function or a purpose. Finally, I realised that these tales were instances of 'atrocity stories' (Stimson and Webb 1975; Dingwall 1977; Baruch 1981; Allen 2001). Atrocity stories are a form of story-telling where other people are presented as somewhat lacking, stupid, or misguided. In contrast, the teller is presented as rational, sensible and morally adequate. The stories are vivid, detailed and often humorous. The chapter will begin with a discussion of previous research

on atrocity stories. This will be followed by a detailed examination of some of these stories told within my interviews, in order to identify some of the methods through which atrocity stories are accomplished. The chapter will conclude with a description of the artful ways in which the social workers used these stories.

## **7.2 Previous research on atrocity stories**

### **7.2.1 Talking about doctors**

Gerry Stimson and Barbara Webb created the term 'atrocity stories' in their book, *Going to see the Doctor* (1975). Stimson and Webb examined women patients' retrospective accounts of their contact with the medical profession. The patients told 'atrocity stories' about doctors to each other during group discussions or in informal conversations observed by Stimson and Webb. The stories were told as eye witness accounts and had a dramatic quality. Stimson and Webb (1975) concluded that the stories were a way in which the patients could redress the inequalities in their relationship with doctors.

Those who see themselves as relatively powerless in a situation can redress the balance by stressing their own human and sensible qualities as against the comic qualities or stupidity of the more powerful, in this case the doctor. By laughing at the professional, he is degraded. (Stimson and Webb 1975 p.107)

Although not explicitly referring to the documentary method of interpretation, Stimson and Webb (1975 p.93) stated that they adopted Garfinkel's 'method' in order to show that common understandings or background expectancies were crucial in understanding the stories. They found that elaboration was not required and that omission was used to emphasise what *was* said. The atrocity stories featured frequent repetition of its main points and the patients used mimicry when repeating phrases the doctor was reported to have said.

Stimson and Webb (1975) stated that they were interested in the way the stories were told and their common themes rather than in the validity of the accounts they provided. However, they also discussed the apparent discrepancy between the active patients that the stories portrayed and the passive patients they observed in consultations with the doctor. Stimson and Webb (1975 p.96) were at pains to point out that these stories differ from the 'fable' (c.f. Dingwall 1977 below) and that the characters and events are at least as important as the moral or the point of the story (c.f. Baruch 1981 below).

### **7.2.2 Health Visitors, Doctors, Nurses and Social Workers**

In his ethnography of health visitors, Robert Dingwall (1977) widened Stimson and Webb's conception of atrocity stories. He concluded:

...we should expect such accounts whenever attempts are being made to control the lives of a group by others whose claim to competence to justify such action is seen as illegitimate. (Dingwall 1977 p.145)

Dingwall was interested in the atrocity stories told by health visitors about other professionals. Like Stimson and Webb, he concluded that the stories were a remedial device by the weaker party in a power relationship and thus could be seen as a mark of social friction. For Dingwall, instead of open conflict, problems were resolved indirectly in the telling of atrocity stories. Dingwall (1977 p.151) confirmed Stimson and Webb's assertion that the degree to which stories trade on shared knowledge: 'Within a group of story-exchanges it may be necessary only to mention key elements of a story to get the relevant response'.

The health visitors in Dingwall's study told atrocity stories about doctors, ward nurses, and social workers. Dingwall showed how these stories performed different functions in relation to the different professions. Dingwall (1977a p.31) concluded that the difficulties health visitors encountered with doctors were 'primarily issues of status equality, the problem of inclusion'. Thus, the stories about doctors were an attempt to blur a sharp distinction between inequalities of status. In these stories,

the health visitors are portrayed as triumphing over the illegitimate claim of superiority by GPs. For example:

Rosemary: The health visitor was worried quite early on, but the GP pooh-poohed it until after the developmental assessment. (Dingwall 1977 p.147)

In contrast, health visitors' difficulties with nurses and social workers 'are issues of demarcation, the problem of exclusion' (Dingwall 1977 p.31). Here the stories told about nurses and social workers were an attempt to sharpen a blurred distinction, 'demarcating between their respective zones of competence' (Dingwall 1977 p.147). The health visitors had all come from a ward nursing background and so the stories were a way of 'facing their own pasts' (p.156). The differences between the health visitors and ward staff were presented in terms of educational standards and autonomy. The health visitors described ward staff as 'poorly-taught, authoritarian and petty' and that they 'reduced patients to objects' (p.159). In terms of the relationship with social workers, Dingwall (1977) found that:

In both training and practice, a major problem in maintaining the identity of health visiting is to find a way of distinguishing between the two occupations. (Dingwall 1977 p.148)

The atrocity stories told by the health visitors present social workers as slow, as lacking in practical knowledge, as having a slack attitude towards confidentiality, and as being both possessive about clients and unpopular with them. The social workers in Dingwall's study were portrayed as only dealing with crises whereas the health visitors described themselves as doing long term preventative work. Humour was used to underline such portrayals:

Field notes: One of the health visitors came in. She says she's been down at the Social Work Department. This provokes a burst of laughter from the other health visitor in the office. (Dingwall 1977 p.151)

For Dingwall, then, the exchange of atrocity stories maintained the integrity of groups. Like Stimson and Webb, Dingwall was not concerned with the ontological status of these stories:

...these stories need not be thought of as 'factual' accounts. They are elements of the oral culture of a group which epitomise aspects of that culture. In this sense they are rather like proverbs or parables. They play on discrepancies between the 'real' and the 'ideal'. (Dingwall 1977 p.155)

Thus, Dingwall extended Stimson and Webb's conception of atrocity stories to redress perceived inequalities between lay people and professionals, to the problems of exclusion and inclusion between different professional groups.

### **7.2.3 Moral tales**

Like Stimson and Webb, Geoffrey Baruch (1981) examined the atrocity stories told by laypeople about their encounters with doctors. In Baruch's study, the atrocity stories were told in interviews by the parents of children who attended a paediatric cardiology unit or who were being treated for cleft palate/hare lip conditions in a children's hospital. Baruch (1981 p.276) found that the parents accomplished the status of moral adequacy through the stories by presenting themselves as 'moral persons, competent members and adequate performers'.

Unlike Stimson and Webb and Dingwall, the paper by Baruch (1981) provided a detailed examination of how the moral displays by the parents are accomplished through the atrocity story. For example, Baruch (1981) discussed the use by parents of devices such as 'you know'; 'of course'; 'you just don't think' to appeal to an 'intersubjective world':

...how 'I/we', i.e. story-teller(s)-parent(s), view 'reality' as opposed to the way 'they', i.e. health professionals, view it. As we shall see in other stories, these devices sometimes make the 'medical' reality seem alien and beyond understanding. (Baruch 1981 p.281)

This is much closer to an ethnomethodological analysis due to the detailed examination of the talk. However, Baruch was not concerned with the boundary work between professions which is the focus of this thesis.

#### **7.2.4 Narrating nursing jurisdiction**

Like Dingwall, Davina Allen (2001) focused on the boundary work between different professional groups. Allen examined the atrocity stories told by nurses on a hospital ward. Allen positioned her work as building on the work of Dingwall (who was her doctoral supervisor) but as different in two important respects. Although Dingwall explored the different social actions for which stories can be used, he was not concerned with *how* these are actually accomplished. Like Baruch, Allen's analysis pays closer attention to the rhetorical and interactional detail of the stories nurses tell. Secondly, Allen argued that Dingwall presented atrocity stories as a way of handling conflict when its overt expression is constrained. In contrast to this psychological explanation, Allen concentrated on the interactional work that atrocity stories demonstrably do, treating nurses' atrocity stories as a form of boundary-work.

Allen found that telling atrocity stories was the principal mechanism through which ward nurses established a sense of occupational difference and constituted nursing as a bounded occupation. Allen was a qualified nurse who undertook an ethnography of a general hospital for her doctoral thesis. She explained that:

My research role ranged from observer to participant, depending on the exigencies of the field. Sometimes I positioned myself at the nurses' station from where I could observe... On other occasions I adopted a more participative role. I assisted with bed making, served meals, fetched patients fresh water, and passed on telephone messages. Indeed, when the ward was busy it was actually very difficult to resist the urge to pitch in. (Allen 2001 p.82)

Significantly, Allen described how she also told atrocity stories 'of my own to establish rapport with the research participants and present myself as someone who



knew 'how things really were'. Allen does not discuss the issue of unique adequacy but it seems clear that, in ethnomethodological terms, Allen engaged in doing being a nurse during the research process. This aligns with my research where my vulgar competence allowed me to understand the atrocity stories the AMHPs told to me in the interviews.

The nurses in Allen's study mainly told atrocity stories about doctors. Allen stated that this was not surprising as nursing and medicine overlap considerably, with nurses as 'subordinate players'. This connects with Dingwall's (1977) findings about the health visitors, as both are in a marginal position. Allen (2001) concluded that these stories accomplished boundary-work in three interrelated ways:

- They employed contrastive rhetoric, juxtaposing the medical and nursing perspective.
- They isolated the doctor, aligning the story recipient(s) with the nursing standpoint.
- Nurses' problems with doctors were formulated as a patterned part of the collective experience, thus underlining their common occupational identity.

Allen (2001 p.76) argued that the atrocity stories performed dual boundary-work: that is, the *rhetorical form* of the stories and the storytelling *practices* function to create a moral boundary between nurses and medical staff, simultaneously working to constitute membership in the colleague group. Allen showed how by using specialised language and trading on taken-for-granted knowledge, nurses' stories work to constitute the local colleague group.

Allen's study connects most closely to my research. It was concerned with atrocity stories as a form of boundary work between different professional groups. Allen was uniquely adequate, and her paper provided a detailed analysis of the ongoing storytelling by the nurses.

## **7.3 Atrocity stories told by the Approved Mental Health Professionals**

### **7.3.1 Being a member and atrocity stories**

In Stimson and Webb's study, the atrocity stories were told by the women to each other in group discussions and informal conversation. When Stimson and Webb asked for clarification *as interviewers*, they described the women as often backing down a little and 'furnished details which showed the account in less black-and-white-terms' (Stimson and Webb 1981 p.100). Stimson and Webb concluded that this meant that the patients were originally 'Overdoing the telling'. Thus, there was a difference in terms of the stories told to other group members and to the researchers.

In the study by Baruch, there is an interesting discussion in the Notes section. In Note 2, Baruch (1981) observed that the atrocity stories often took a truncated form in the formal part of the interview but were then repeated in an elaborate manner during the informal stage. Baruch explained this in terms of the parents' conception of the interviewer. At first the parents saw the researchers as connected to the hospital and so offering 'unreserved criticisms...was initially problematic' (p.294n.).

However, it soon became apparent that we were sympathetically disposed towards their point of view. From an analysis of the talk, it will be seen that our utterances display us as members who share and affirm our respondents' everyday 'reality'. Thus the repetition and elaboration of their stories was in order. (Baruch 1981 p.294n.)

Dingwall (1977 p.145) found that atrocity stories 'play an important part in defining the colleague group, those to whom one can tell such stories and from whom one receives them'. He concluded that:

Acquiring an appropriate repertoire of such stories and being able to identify appropriate occasions for telling them are important parts of becoming recognized as a competent member of an occupation. (Dingwall 1977 p.29)

For Dingwall, it was only the occupational members who could tell such stories and only where the majority of the audience shared the same group identity. He observed that whilst the student health visitors would criticise nursing when they were together as a group, they were very reluctant to accept criticism from anyone else or to voice it publically. Dingwall (1977) noted:

The same tutor commented to me that she felt that the students were reluctant to voice criticisms of nursing in discussion when I was there...In the presence of non-members, like myself, story-telling becomes much more problematic. (Dingwall 1977 p.158)

In contrast, the nurses in Allen's (2001) study told atrocity stories in front of and directly to her. Indeed, Allen herself told atrocity stories to the nurses. Crucially here, Allen was a member of the nursing occupation.

Thus, when the AMHPs told me atrocity stories in the interviews this can be seen as demonstrating that they treated me as a group member. Thus I was a group member in the sense that Garfinkel (2005 p.197) described: 'If Y *treats X as a group member, then X is a group member*'. In ethnomethodological terms, we were 'talking as *bona fide* professional practitioners about usual demands, usual attainments, and usual practices' (Garfinkel 1967 p.14). The discussion will now move to an in depth analysis of some of the atrocity stories told by the social workers.

The health visitors in Dingwall's (1977) study told atrocity stories about doctors, ward nurses, and social workers. As discussed earlier, Dingwall showed how these stories performed different functions in relation to the different professions. The stories about ward nurses and social workers were an attempt to demarcate the blurred distinction between the role of these professions and the health visitors. In contrast, the stories about doctors were an attempt to blur a sharp distinction between inequalities of status. For the AMHPs, stories about the nurses in the CMHT can be seen as an attempt to demarcate the blurred distinction. In contrast, the stories told by the AMHPs about psychiatrists and other doctors in the CMHT can be

seen as an attempt to blur a sharp distinction between the status of the social worker and that of the doctors. This will now be explored in more depth.

### **7.3.2 The problem of exclusion: the nurse as other**

Dingwall (1977) argued that the health visitors were a particularly useful profession to study because of the marginal position occupied by this profession. In Dingwall's study, the health visitors' role overlapped with that of social work and nursing. This marginal position caused problems of exclusion as the health visitors 'attempt to identify and maintain the discrete character of their occupation from pressures to assimilate them' (Dingwall 1977 p.28). Thus the atrocity stories were about ward nurses and social workers. For example, the health visitors thought that social workers were slow, lacking in practical knowledge, questioning medical judgements, slack about confidentiality, and unpopular with service users. In the study by Allen (2001) where the overlap was between nursing and medicine, the nurses told atrocity stories about doctors.

The social workers interviewed in the individual interviews also occupied a marginal position with their CMHT. They were separated from other social workers and based in Health Trusts where they were the only non-health professional or where there were only one other social work colleague. In terms of other professionals in the team, nurses undertake the most similar tasks to social workers with both acting as Care Co-ordinators for service users. In addition, the introduction of the Approved Mental Health Professional role means that the only unique social work role (i.e. the Approved Social Worker) can now be undertaken by other professionals. Significantly, although occupational therapists and psychologists can also take on the AMHP role, in reality only nurses are likely to do so. The General Social Care Council (2012) inspected AMHP courses in England and found that since the AMHP role was introduced in November 2008, 936 candidates had successfully completed AMHP training. Of these candidates, 788 (84%) were social workers; 140 (15%) were nurses; 8 were occupational therapists; and no psychologists had trained as an

AMHP. Like Dingwall's health visitors then, the social workers are attempting to identify and maintain the distinctive nature of social work from the competing claims of nursing. Therefore the atrocity stories can be seen as boundary work in the way as Allen (2001) described.

### 7.3.2.1 The Mars bar story

The first atrocity story to be examined comes from the interview with Eva. This story was notable as it was not just contained in one reply but extended over a section of the interview. Eva had explained that there is an expectation that social workers are able to solve every problem that a service user might present. Eva then illustrated her point with a story which I have called the Mars Bar story.

Eva: I know in ward rounds the doctor will say "*Ooo now*" to the patient "*you've not been doing this*" and they'll look at me and go "*do you think you can sort that out?*" and I think, right, how do you think I'm going to make that person they're not doing any exercise for instance umm or they're diabetic and they're refusing to stop eating a bowl of a million Mars bars and look at me and go "*you'll look into that?*" and I'll go "*yeah*" or "*I'll manage that*".

Through her story, Eva is demonstrating how social workers will take on tasks that are not clearly related to social work. She uses the examples of 'exercise' and 'diabetes', both of which are not associated with the role of social workers. Here Eva demonstrates her artful use of active voicing to add a sense of drama and vividness to her account. The ward round is brought to life by the use of the present tense through her active voicing of what the doctor said and her report of what she was thinking at the time. Eva also uses active voicing to describe the interaction between the doctor and herself. It is interesting that she says 'I'll go "*yeah*" or "*I'll manage that*"' as the use of 'or' implicitly acknowledges that it is not a faithful representation of what actually happened in one ward round. Instead, it is reported as an approximation of what *she might have said had she been in that specific situation*. This is another example of where the term active voicing is more accurate than the term reported speech (Wooffitt 1992). Eva continues this reply:

1       Eva: And I think yeah I think that. I mean on the other hand that can be a  
2       bad thing or it can be a good thing because it's like you own somebody  
3       that case is yours. When you do when you're got a good grip on a case  
4       and you are powerful and you'll sit in the ward round or you'll sit in the  
5       tribunal and you'll say: "*no, you don't know what you're talking about. I*  
6       *know this person. I know everything about them. I'm involved in every*  
7       *area of their life and you're talking rubbish. This is wrong. You need to do*  
8       *this*". And I think that's great when you know a client. And I suppose it's  
9       more difficult when you don't know your client or you've not got the  
10      time to have got to know them really well and that sort of thing. Umm  
11      because I don't know how social work could be more boundaried really. I  
12      don't know. Because that is our job. Floating around and Hoovering up  
13      the mess. And that's what we do.

In a very interesting phrase, Eva says that whilst this expectation can be difficult, it can also 'be a good thing because it's like you own somebody that case is yours' (line 2-3). Being a bona-fide member, I understand the point that Eva is making here. When you have a detailed knowledge of all the circumstances of a case, you are able to advocate on behalf of a service user in the ward round or Mental Health Tribunal. Eva expresses this through active voicing in a three part list [*'I know this person. I know everything about them. I'm involved in every area of their life and you're talking rubbish'*]. It is interesting here that Eva uses the term 'client', a social work term, here when discussing this more advocating role, compared to the more passive 'patient' that she used in the first extract of the Mars Bar story. Eva concludes this very long reply with another key definition of social work. She depicts social work as: 'Floating around and Hoovering up the mess' (line 12-13). Once again, social work is presented as having an indistinct role; being without clear boundaries or margins; and as filling in the gaps. Like Ed's earlier definition of social workers as being the people 'who mop up the stuff that other people don't want to do', Eva portrays social work as being concerned with 'the mess'. These portrayals resonate with the words of Hughes (1971 p.344) quoted earlier: the 'dirty work may be an intimate part of the very activity which gives the occupation its charisma'.

Later in the interview, I pursue the issue of social work as having unclear boundaries by returning to the Mars Bar story.

1 Lisa: And in that situation in the ward round, have you been there with  
2 nurses and that has happened? Would they say to the nurse "*oh they're*  
3 *doing this, sort it out, they're not doing their exercise*" or would that be  
4 seen as are there certain issues where they wouldn't say to the nurse but  
5 they would say to the social worker? Or do you think that the doctors  
6 would say that to anybody?

7 Eva: I think they would say that to anybody because they don't see the  
8 difference but the difference would be is that the nurse would look  
9 blankly at them and say "*oh, I'll refer them*" they'll say "*oh, I'll try and*  
10 *refer them to*" or they'd give that back to the doctor and say "*oh, you*  
11 *need to refer them to a dietician*". Do you see?

12 Lisa: Yes

13 Eva: Whereas as a social worker you feel that I should be able to sort out  
14 those Mars bars. I should be able to do something about that

15 Lisa: [laughs] yes.

Eva makes several points here. In her story Eva singles out a nurse to display the differences between social work and other professions. Like the health visitors in Dingwall's (1977) study, it is nurses and social workers who hold 'marginal' positions within the CMHT. The move to care coordination means that there is an overlap between the roles and tasks that social workers and nurses undertake. Thus, the nurses and the social workers are aware of and alert to claims of difference. Conversely, the doctor is presented as not knowing the difference between nurses and social workers (line 7). Unlike nurses and social workers, doctors hold a clearly defined position within the CMHT. This means that they are not engaged in boundary-work with other professionals. The nurse is presented as looking 'blankly' at the doctor, a somewhat disparaging term, because the request does not fit in with the clearly defined nursing role (line 9). In direct contrast to the social worker who feels that she 'should be able to sort out those Mars bars' (line 13-14), the nurse is described as passing the task to another professional - the dietician (line 10-11). Dietician is category-bound with eating-issues and so can be identified as the 'correct' professional to undertake the task. The function of the atrocity story is to show that social workers will take on more than nurses and that they will undertake

work that is outside the social work role. My laughter and affirmation demonstrate that I understand the story, thus exhibiting our shared 'natural' competence (line 15). Eva continues her reply:

1       Eva: I think that there's an element that we will take on more. And I  
2       think that maybe I don't know if that's a historical thing in social work  
3       that we've traditionally done more complicated things than nurses. And  
4       now we do the same jobs now nurses have to do tribunal reports I think  
5       that's very recent within the - it wouldn't have been that long ago that if  
6       a nurse had a patient on the ward and if a tribunal they would give that  
7       tribunal report to the social worker despite the fact that they'd never  
8       met the person they'd be that kind of and perhaps that's more to do  
9       with nurse training that they're trained to be really hierarchical. And  
10       they're always much more nervous of their opinions I think we're more  
11       strident. We'll argue with the doctor whereas the nurses tend to be  
12       much more [pause] respectful is the wrong word it wouldn't be that they  
13       respect doctors they would [long pause] they wouldn't reflect if they had  
14       a different opinion they wouldn't reflect that to the doctor whereas the  
15       social worker would say "*oh, no. I think it might be more this*".

Again, the nurse is presented as the other here. Eva directly contrasts nurses and social workers. Firstly, social workers 'take on more' (line 1) and do 'more complicated' work (line 3) whereas nurses are 'trained to be really hierarchical' (line 9). Secondly, nurses are 'always much more nervous of their opinions' (line 10) compared to social workers who are 'more strident' (line 10-11), thus fitting with the idea of social workers as assertive. Finally, whereas social workers will 'argue with the doctor' (line 11), nurses will not voice 'a different opinion' (line 14). Eva then continues with the Mars Bar story.

1       Eva: Umm so in some ways perhaps nurses are more - have less power  
2       than we do so perhaps we have more ability to go and [pause] you know  
3       have a go at the Mars Bar thing whereas perhaps the nurse might think  
4       "*I have no idea how to go about the Mars Bar thing*" whereas we might  
5       feel "*Oh I can go and do a bit of research about that*" or I can sit there  
6       and I think social workers are a bit more pushy with their patients. Umm  
7       I know if I go and do assessments with nurses they'll be pushy it's  
8       interesting because they'll be pushy about medication whereas I as a  
9       social worker don't even ask which medication they're on. It always goes  
10       out of my mind can't remember. But everything else they're very  
11       passive. We push don't we? "*Well, why? Are you? Will you?*" "*And if I*



12        *come at nine o'clock, will you come out with me?" "You're going to do*  
13        *that?"* Whereas nurses are more medical. They give, they give the  
14        treatment and if the people don't want it they don't want it. So that's  
15        how that is the difference in the philosophy of the training, isn't it?  
16        We're trained that empowerment thing is, you know, empowerment  
17        with the hand in the small of the back [laughs]

18        Lisa: [laughs]

19        Eva: And the nurses are treating ill people.

The use of active voicing emphasises the direct contrast between the response of the nurse and the social worker to 'the Mars Bar thing' (line 3). Again, it is apparent that this is not reported speech but active voicing – it is what the nurse 'might think' (line 3) and a social worker 'might feel' (line 4-5). The social worker is depicted as having more power and will 'have a go' (line 3). Thus, a social worker will not only take on a task that is outside the social work remit but is also able to be proactive. In contrast, the nurse is presented as passive and as lacking ability and knowledge (line 2-5). The use of 'we' authorises Eva's version (line 2 and 4): it is not just Eva's personal opinion but a collective view - the view of social workers in general. Eva uses the word 'perhaps' three times in the first three lines. Rather than casting doubt on her statement, this suggested tentativeness can be seen as adding to the credibility and plausibility of the account.

Eva continues to contrast nurses and social workers in terms of being 'pushy' with service users. In a direct contrast, when undertaking an assessment nurses are only 'pushy' about medication (line 8) and are 'very passive' about everything else (line 11) whereas social workers are 'more pushy' about everything other than medication. In the final part of her reply, Eva explains these differences between nurses and social workers as resulting from the 'difference in the philosophy of the training' (line 15). She contrasts the social work concept of 'empowerment' (line 16) with the medical model of 'treating ill people' (line 19). The use of 'we're' and 'you know', and the shared laughter about 'empowerment', a social work shibboleth, demonstrates that Eva recognises me as a group member because it is not a joke

that you would tell to an outsider. Unlike nurses, occupational therapists (OTs) are presented as aligned with social work in the next part of her reply.

1       Eva: And there's other professions, aren't there, such as the OTs and err  
2       umm [pause] err the psychologists. And I think I think that OTs they face  
3       very similar-ish problems in their role. I think that while their role is clear  
4       it's so kind of not concreted within the trust so that they'll certainly end  
5       up doing social work. I think that they get quite upset that they should  
6       have caseloads of ten people where they do OT. And they don't do OT,  
7       not at all. They do social work

8       Lisa: Because the Mars Bars thing would be OT [laughs]

9       Eva: OT [laughs] absolutely. They'd be in there with Mars Bars.

Unlike social workers, occupational therapists (OTs) are presented as having a clear role (line 3). However, being placed within a Health Trust means that their role is less concrete (line 4). What is interesting here is that Eva describes the OTs as 'doing social work' (line 7) and not, for example, nursing. This is not explained in the narrative. Dingwall (1977 p.35-36) argued that atrocity stories may become highly truncated because of the degree to which these stories trade on shared knowledge. From my social work experience of working in CMHTs I recognise that OTs have reluctantly had to take on the role of care coordinator instead of solely undertaking OT assessments. I also recognise that OTs are trained to have a holistic view and work with service users on all aspects of their lives; in this way, OTs share the same approach to service users as social workers. This exchange is an example of the documentary method of interpretation. As in the Dana story, Eva does not have to elaborate here but pre-supposes that I share this common scheme of interpretation. My joke about the 'Mars Bars thing' being an OT role displays my recognition and acceptance of Eva's statement (line 8). The use of taken for granted knowledge is a key element of the account: 'Insiders "get" the moral point of the tale from the available information: outsiders do not' (Allen 2001 p.93). Here Eva and I co-narrate the narrative and our shared laughter affirms our accomplishment of social work identity. Eva continues her reply by moving on to briefly discuss psychologists, another profession in the CMHT.

1 Eva: Psychologists are fairly well protected umm on our team. They do  
2 psychology [pause]. They don't, you know [pause]. They're like medics.  
3 They have that privilege. Very very rigid structure to their umm job. But I  
4 don't know the more we work together if that will change. But then the  
5 training's always going to be different

6 Lisa: So do you very much think that it comes from the training, the  
7 philosophy?

8 Eva: I mean, I'm just thinking about it now. It must do I suppose, it must  
9 do, must do. We will come into the job wanting to change people's lives.  
10 Nurses do not. They come in wanting to make people better. It's a  
11 different idea isn't it? And we're sort of trained in that non-medical  
12 thing. The idea of better to us doesn't mean the same thing, you know.  
13 We probably spent less time talking to people about their symptoms and  
14 that sort of thing. We look at different things. I mean we do, it is  
15 important but certainly not. I mean I've been out on assessments with  
16 nurses and who sit there and say to people "*so, do you hear voices? Are*  
17 *you thoughts racing?*" and the person is sitting there going "*no, no, no*"  
18 and you're sitting there thinking "*they're obviously mad aren't they?*"  
19 and the nurse comes away and goes "*well, they're fine*" and they're not  
20 are they? [laughs] But it's very [pause] you know. It's very medical. The  
21 guy was knocking his house down so it was obvious to me but the nurse  
22 didn't seem to notice that.

23 Lisa: So you said before that when you're in the ward round and the  
24 doctors are saying about the Mars Bars, and you said that they don't see  
25 they don't know there's a difference. You don't think that they see a  
26 difference between you and the nurses?

27 Eva: I don't think so. They just see that that's not their job and that  
28 someone else will do that. Yeah, no. It will be the nurse or social worker  
29 that sees the difference in that. We have different attitudes towards  
30 that.

Like doctors, psychologists have a narrow job specification and do not have to take on the more generic role of care co-ordinator. Eva highlights a long-standing debate in mental health services about genericism versus distinct roles ['I don't know the more we work together if that will change. But then the training's always going to be different']. Moving away from OTs and psychologists, Eva once again contrasts nurses and social workers. For Eva, social workers want to 'change people's lives' (line 9) which fits in with social work being positioned as inherently associated with

the social model and social justice. In contrast, nurses are described as 'wanting to make people better' (line 10). For nurses, then, the focus is changing something within the individual in a medical sense. Thus, nurses are concerned with medical 'symptoms' (line 13) whereas social workers are 'trained in the non-medical thing' (line 11). This contrast in the use of language fits with that outlined by Jerry Tew (2011). Tew (2011 p.9) provided a comparison between the languages of the biomedical model and the social model to mental distress. The biomedical model uses language such as 'mental illness', 'symptom', 'diagnosis', 'treatment', 'cure', and 'care'. In comparison, the social model uses language such as 'mental distress', 'experience', 'meaning', 'action-planning', 'empowerment', and 'self-directed support'. The focus of the medical model is on treating ill people as individuals, whereas the social model 'privileges a systemic...way of viewing distress: it aims to see a person in relationship with their social and cultural context' (Tew 2011 p.16). In this section, Eva uses the collective 'we' five times, demonstrating her group membership.

Eva then uses a story to illustrate the points that she has made. In this atrocity story the social worker is placed as having a full picture of the situation compared to the much more limited view of the nurse. It was 'obvious' to Eva but the nurse 'didn't seem to notice' that the 'guy was knocking his house down' (line 21-22). The use of such a dramatic example displays the degree of just how limited the nurse's view of the situation was. S/he is 'very medical' and only concentrates on the symptoms of mental distress ["*so, do you hear voices? Are you thoughts racing?*"]. The limited medical view of the nurse ["*well, they're fine*"] is contrasted with that of the social worker who is the only person who is able to see the reality of the situation [*they're obviously mad aren't they*]. Again the repeat of the word 'obviously' is used to 'authorise' the version (Smith 1978). The use of active voicing in an interaction and the laughter contributes to the sense of immediacy and drama of the atrocity story. In effect, Eva contends that a true picture of what is happening can only be obtained through the social work perspective.

My next (lengthy) question returns to the Mars Bar story and asks for more clarification about the doctors in the ward round not seeing that there is a difference between social workers and nurses (line 23-26). Eva echoes the point she made earlier: the doctors have a clear role and so are able to demarcate that this is outside of their remit (line 27-28). It is nurses and social workers that are engaged in a process of boundary demarcation and so are aware of and alert to difference (line 28-30). This is the final part of the Mars Bar story which has developed over the interview. It provides a clear illustration of the documentary method of interpretation.

Many matters were understood through a process of attending to the temporal series of utterances as documentary evidences of a developing conversation rather than as a string of terms...In attending to the utterances as events-in-the conversation each party made reference to the biography and prospects of the present interaction which each used and attributed to the other as a common scheme of interpretation and expression. (Garfinkel 1967 pp.39-40)

The Mars Bar story was a 'developing conversation' in which we both attended to the 'temporal series' of the talk, with the motif of the Mars Bars displaying a 'common scheme of interpretation and expression' throughout.

### **7.3.2.2 It's not rocket science**

This analysis of how atrocity stories were used to achieve demarcation of the social work roles and exclusion of non-social workers will conclude with an examination of another example of the nurse as other. This story was told by Andrew. My question refers to Andrew's story about his stock line that '*nurses nurse and social workers do everything else*' which was examined in the last chapter in the section on doing non-seriousness. This is another example where the 'follow up' question occurs much later in the interview.

- 1 Lisa: And would you say, when you said that, umm when you joked that
- 2 in the older people's team the nurses did the nurse work and the social

3 workers did everything else, in where you are now where there is  
4 obviously less of a gulf, how does it work there?

5 Andrew: I think that the nurses feel aggrieved at some of the things that  
6 they have to do whereas the social workers feel that it is just one of  
7 those things. I mean just thing like moving people, things like that,  
8 helping people to pack boxes, it's not rocket science

9 Lisa: [laughs]

10 Andrew: it really isn't. We're not talking about deep theoretical kind of  
11 things here we're talking about packing boxes for people, sticking them  
12 in the back of your car and moving them, you know. The nurses feel,  
13 they do it but they really feel that that should not be part of their job at  
14 all, whereas, you know, it's that thing, well, who else is going to do it so  
15 it's a no brainer, you've got to do, you've got no choice whatsoever, so  
16 you do it

17 Lisa: Exactly. Do they think that you should do it, then?

18 Andrew: Yes.

19 Lisa: Yes even though they see it as a nothing kind of thing to do?

20 Andrew: Yes, I think underneath they do. Yeah, and they put umm they  
21 drag their heels with it a lot more, you know, moan about it a lot more  
22 and you can really feel that they do not think that is part of the nursing  
23 role to do that, well they don't, they don't think it is, you know. So they  
24 know they've got to do it and in the older person's team the splits were  
25 so big that, I mean, a classic example was I had an old lady who, a sixty-  
26 seven year old lady with schizophrenia who had no social care needs  
27 whatsoever, she was completely independent, voice-hearer, so very, you  
28 know, she went through a really really hard time thinking the neighbours  
29 were basically talking to her from either side of her so she requested a  
30 move and the nurse involved umm handed that side of things over to me

31 Lisa: [laughs] ok

32 Andrew: And all I did was register her with the local housing department  
33 to help her move, you know. And when it finished, I sat the nurse down  
34 and said "*do you really think that you should have done that*", you know,  
35 "*given that it took me three months*", you know, "*you saw what I did*",  
36 you know, "*come on*", you know, and she admitted, it was one of the  
37 nurses who was a little more proactive about things, who was less  
38 entrenched in that traditional way of working, "*you right, you're*  
39 *absolutely right*", but she'd been almost conditioned [pause] into [pause]

40 it was the, it wasn't even a second thought for her, "*she's moving, I'll*  
41 *give it to Andrew*", and I was the only social worker on the team as well,  
42 which didn't help, it was a very small team. But that's just a classic  
43 example, but that's not the same where I am now.

Again a nurse is the subject of this atrocity story. As a result of there being less of a split in this team, there is more overlap between the nursing and social work roles. The nurses are presented as feeling 'aggrieved' (line 5) that they are having to do tasks that they see as outside of the nursing role whereas the social workers 'feel that it is just one of those things' (line 6-7). The word 'just' is used twice in quick succession to show how minor it is. Andrew uses humour – 'it's not rocket science' (line 8) - at the expense of the nurse and my laughter affirms my understanding of the joke through my vulgar competency (line 9). Andrew continues with this ironic slant ['We're not talking about deep theoretical kind of things here we're talking about packing boxes for people, sticking them in the back of your car and moving them, you know'] positioning the nurses as somewhat clueless. The nurses 'really feel that that should not be part of their job at all' (line 13) which again affirms his previous description of nurses as having a 'fixed' identity and a clearly defined role. In contrast, for a social worker 'it's that thing, well, who else is going to do it so it's a no brainer, you've got to do, you've got no choice whatsoever, so you do it' (line 15-16). This contrast links back with Andrew's earlier phrase that the nurses nurse and the social workers do everything else. Once again, social work is presented as having an indistinct role, a lack of boundaries, and as filling in the gaps left by other professions. My affirmation of 'Exactly' demonstrates that we share the same background expectancies (line 17).

In the next part of the narrative, Andrew and I both frequently use the pronoun 'they' which further positions the nurses as other through an 'us and them' distancing device (line 17-24). Again the response of nurses and social workers are contrasted: the social workers just 'do it' (line 16), whereas the nurses 'drag their heels with it a lot more, you know, moan about it a lot more and you can really feel that they do not think that is part of the nursing role to do that' (line 21). Once

again, this reinforces the point that Andrew is making that the nurses have role clarity in contrast to the social work role as indistinct.

In the last part of the narrative, Andrew illustrates his argument by providing another story about the older person's team in order to display how 'the splits were so big' (line 24-25). The description of this being a 'classic example' implies that it is archetypal (line 25). By stressing that there were 'no social care needs whatsoever, she was completely independent' (line 26-27), Andrew delineates that this was not a 'social work case'. However, once the service user wishes to move house, the nurse involved is described as referring this task to Andrew rather than undertaking the task themselves because it is outside of the nursing role. My laughter here shows that I recognise that this is an atrocity story (line 31). The use of the phrase 'all I did' denotes how minimal it was to register the service user with the housing department (line 32). Andrew depicts how he 'sat the nurse down' to talk to her thus making it more noteworthy and formal (line 33). Once again, the use of active voicing in a dialogue adds to the immediacy and authenticity of the story (line 34-41). Through repeating the phrase 'you know' as an aside four times during the sentence Andrew alludes to our shared social work identity. The use of the word 'admitted' (line 36) implies that that the nurse knew she was in the wrong as does the use of her reported speech '*you're right, you're absolutely right*' (line 38-39). The description of the nurse as 'a little more proactive about things, who was less entrenched in that traditional way of working' (line 37-38) shows that even these qualities do not prevent her being 'almost conditioned' (line 39). Here the word 'conditioned' implies a 'cult-like' state. The phrase 'it wasn't even a second thought for her' is demonstrating how 'entrenched' the nurse is (line 40). Andrew ends the story by reiterating that this is a 'classic example'.

These two stories by Eva and Andrew clearly demonstrate how the atrocity stories about nurses are an attempt to demarcate the differences between nursing and social work. Both of the stories work to provide a portrayal of social work through a direct and explicit contrast with nursing. The next section will examine two stories



with accomplish the other function outlined by Dingwall (1977); namely, to blur a sharp distinction between inequalities of status.

### 7.3.3 The problem of inclusion: stories about doctors

Whereas the stories about nurses can be seen as an attempt to sharpen a blurred distinction between nursing and social work, the aim of the next section is to explore two atrocity stories which can be seen as an attempt to blur the sharp distinction between the inequalities of status between social workers and doctors. The first story is from the interview with John.

#### 7.3.3.1 Triumphant over a 'slimy' consultant

The story begins when I ask John about how he finds the more controlling aspects of social work.

- 1 Lisa: I'm wondering then how did you cope with the more controlling  
2 aspects of social work. Did you find those challenging?
- 3 John: No I don't think I did because after [name of his former employer]  
4 where I'd felt frustrated at times I felt I wanted to be more directive  
5 because that was more helpful to people. And then obviously doing the  
6 ASW course where you are taking people's liberty away from them I  
7 could always see the reason for it. Umm but it did make me a very  
8 careful practitioner when it came to actually making that  
9 decision. I mean I've been in many, many fights with consultants who say  
10 "*this person needs to be in hospital*" and I say "*no they don't*". Umm I can  
11 give you an example if you want one?
- 12 Lisa: Yes please give me an example.

John does not appear to see the control aspect of mental health social work as 'dirty work' (Hughes 1948). Instead, it is 'more helpful to people' (line 5) and John 'could always see the reason' for detention (line 7). However, John stated that he does not always think that detention is necessary and this has caused 'many, many fights', an extreme case formulation, with psychiatrists who disagree with this decision (line 9-10). Here active voicing vivifies the apocryphal interaction, adding drama and brings

the disagreement to life. Once again, social workers are shown as assertive. Rather than continuing with the story, John orientates to the interview situation by asking me if I would like him to give an example (line 11). Once this is confirmed, John begins an extended story about a Mental Health Act assessment. It may be that by overtly gaining my permission to tell the story, John feels able to hold the floor for a longer turn than the usual turn-taking pattern in an interview.

1 John: Ok. There's one consultant who's who has [laughs] we always call  
2 him the psychopath and I think in some ways we're not far off the truth.  
3 A lady who I when I was in childcare when I say childcare it wasn't purely  
4 childcare it was everything. About eighty five per cent of your work was  
5 childcare but you got involved with mental health and everything. And  
6 this lady who lived with her mum had serious, serious mental health  
7 problems and was a serious suicide risk when she was poorly. But I  
8 worked with her and helped her and I knew her mum, I knew the family  
9 and I knew her well. Well I was at [name] at the time and I hadn't seen  
10 her for two years and then this consultant rang me and said "*this person*  
11 *has become ill*" and I said "*right. I'll go and assess her*" and I went with  
12 the GP from the [name] who was superb umm and I knew him  
13 reasonably well. And so the consultant had left his pink piece of paper  
14 like they always do and me and the GP went to see her. This was on a  
15 Friday afternoon

16 Lisa: The usual

17 John: The usual time umm and this is usual from this consultant because  
18 he just does it. He thinks nothing at three o'clock on a Friday afternoon  
19 saying "*we need an ASW assessment*". Me and the GP went and she  
20 would accept a depot medication. The GP was on call on Saturday and  
21 we put a package together she was there's no two ways about it she was  
22 quite dangerous in terms of committing suicidal. Her mum was there.  
23 Her sister had come up and was there. Her sister was sleeping they  
24 shared a double bed when the sister came up. Her mum said "*I will look*  
25 *after her I will be with her twenty four hours a day. If I have to go out the*  
26 *next door neighbour will come in*" and I knew that they would supervise  
27 her. So me and the GP put a package together. The medication was on  
28 board. I said on Sunday I'd visit I know it's a day off but I would come and  
29 visit on the Sunday and we'll see how things go. But both of us were  
30 there and if need be I asked him to complete his recommendation just in  
31 case and if necessary I could just go down and complete and I think I  
32 even gave the mother my home telephone number umm because I  
33 trusted her. So the GP went in on the Saturday and I went in on the  
34 Sunday and everything was still holding together. Umm but on the Friday

35 night when I'd put this package together I rang the consultant to say  
36 *"look – this is what we're doing"* and he said *"that is totally irresponsible.*  
37 *She is a high suicide risk"*. *"I accept that"* I said *"but"* I said *"she'll get*  
38 *more supervision where she is than she will on the psychiatric ward*  
39 *where there's"* I can't remember how many there's on twenty on two on  
40 at night. I said you know *"she'll get more supervision where she is, she*  
41 *will recover better where she is, her medication's on board and we're*  
42 *putting a package together"*. Well that oh he threatened me with the  
43 court and all sort anyway I put I was on my mobile phone and I just  
44 clicked it off. But I was asked to do a presentation to the junior doctors  
45 and so I went and took this as a piece of work, anonymised it and said  
46 *"this is a piece of work about keeping people in the community rather*  
47 *than using the mental health act"*. He the consultant was chairing it  
48 [both laugh] and at the end the consultant said *"oh yes I was there*  
49 *wasn't I?" "I'm sorry but you were not" "Oh I was there in spirit"* so this is  
50 how slimy he is err but I got my point across.

Here John tells a long narrative about his dealings with a consultant psychiatrist. He begins by introducing the two main characters: the psychiatrist and the service user. The psychiatrist is described as a 'psychopath', at first with laughter, but then further justified with 'we're not far off the truth' (line 2). The use of the collective 'we' adds to the 'authorisation' of this claim. The service user is a 'lady' with 'serious, serious mental health problems and was a serious suicide risk when she was poorly' (line 6-7). Repeating 'serious' three times in this sentence is an extreme case formulation (Pomerantz 1986) which stresses the severity of her mental distress. Despite this severity, as evidenced by the 'But' at the beginning of the sentence, John was able to work with her and help her (line 7-8). John doesn't specify how or what this 'work' involved. Similarly, Pithouse (1984 p.411) found that the social workers in his study did not 'articulate their exact practices, it is sufficient to say only that one will continue to 'work with' parents and children'. Sharing the same set of competencies means that understanding about what this 'work' involves is 'known, used, and taken for granted' (Garfinkel 1967 p.29) by both of us. John then continues with a three part list: 'I knew her mum, I knew the family and I knew her well' (line 8-9). Using this rhetorical device adds authority to John's assertion that he knew the woman and her family well, even if he follows this by stating that he had not seen her for two years.

Now that the background to the story has been set, John moves from the 'past' to the 'present' by using active voicing to report the initial conversation between him and the psychiatrist (line 10). John went to assess the service user with a 'superb' GP who, like the service user and her family, John already knew 'reasonably well' (line 12-13). John's statement that the psychiatrist had 'left his pink piece of paper like they always do' (line 13-14) can probably only be understood by vulgarly competent members. The doctor completes a medical recommendation which is printed on pink paper and is one of the formal statutory forms used in compulsory admission to hospital under the Mental Health Act. The phrase 'like they always do' (line 14) positions all psychiatrists, rather than just this particular one, as completing their medical recommendation prior to the formal assessment by the AMHP and the other doctor and thus not being part of a joint assessment. In contrast, John and the GP are positioned as conjoint ['me and the GP went to see her'].

The next exchange can be seen as another example of the documentary method of interpretation. From being an Approved Social Worker, I am able to recognise that 'Friday afternoon' (line 15) is the worst time to get a referral because it cannot be left to the following day. It is also common to receive a referral from psychiatrists who are able simply to complete a medical recommendation form and go home. In contrast, the AMHP has to stay until the assessment is completed as it is their statutory duty under the Mental Health Act to convey the detained person to hospital. I acknowledge my recognition of the reference ['the usual'] and John affirms this ['The usual time']. John and I both understood this without having to mention any further details. Thus, each of us 'made reference to the biography and prospects of the present interaction which each used and attributed to the other as a common scheme of interpretation and expression (Garfinkel 1967 p.40). In an aside to the story, John confirms that this is common behaviour from this psychiatrist ['this is usual from this consultant because he just does it. He thinks nothing at three o'clock on a Friday afternoon saying "*we need an ASW assessment*"'] before returning to the story.

Again, the GP and John are positioned as conjoint (line 19). The next phrase is also an example of indexicality and the documentary method of interpretation: 'she would accept a depot medication' (line 20). Here 'she' is an indexical expression. It is clear to me that John is referring to the service user and not her mother or the GP, for example. I recognise this as 'depot medication' is category bound with 'mental health service user'. A 'depot' is a form of anti-psychotic medication given by injection into the buttock. It is given by a nurse at a 'depot clinic', fortnightly or monthly. Being 'on a depot' thus demarcates someone as having a formal mental health diagnosis such as schizophrenia. Again, John and the GP are positioned as conjoint: 'we put a package together' (line 21). A 'package' is a term used in care management under the NHS and Community Care Act 1990. Once a person's needs have been assessed by a social worker, a care plan or 'package' of services is put together to meet the identified needs. John acknowledges that there was a 'quite dangerous' risk of the woman attempting suicide (line 22). However, the repeat of 'was there' positions both her mum and her sister as very much present, even during the night. This is emphasised by the use of active voicing:

John: Her mum said "*I will look after her. I will be with her twenty four hours a day. If I have to go out the next door neighbour will come in*".

The repeat of 'will' in a somewhat emotive three part list adds weight to the degree of supervision. John then reiterates that this was a joint decision ['So me and the GP put a package together']. The GP was to visit the following day [Saturday] and John arranges to visit on the Sunday. It is very unusual and extremely rare a social worker to visit a service user on a weekend (unless part of an out of hours outreach or crisis team). This is implicitly acknowledged in an aside to the story: 'I know it's a day off but' (line 28). This is followed with another unusual practice when John says that he 'even' gave the mother his home number 'because I trusted her' (line 32). Finally, John reiterates that he acted jointly with the GP ['But both of us were there'] and that he has made a contingency plan by asking the GP to sign the second medication recommendation form (line 30). This means that he would be able to use the two

recommendations to make an application for admission to hospital under the Mental Health Act.

The final part of the story is interesting as it starts by making it clear that the 'package' was a success by moving forward in time: 'So the GP went in on the Saturday and I went in on the Sunday and everything was still holding together' (line 34). The story then returns back to the Friday night ['Umm but on the Friday night...']. The phrase 'Umm but' signals that something incongruous is about to be introduced. The story then moves to the present tense through the use of active voicing of the telephone conversation between John and the psychiatrist (line 36-42). Here John is able to justify the decision that he and the GP have taken. Of course, it has already been made clear that the decision was the right one. John ends this part of the story by terminating the call. However, this is not the end of the whole story as the use of 'but' signals that there is another development (line 44). John was 'asked' (being asked invokes status) to do a presentation for the junior doctors (line 44). Again, the story moves to the present tense through the use of active voicing, adding immediacy and drama (line 46-49). The coda to the story is that John 'triumphs' over the 'slimy' consultant (line 50) by making it clear that the psychiatrist was not part of this successful instance of keeping someone in the community [*"I'm sorry but you were not"*]. We both laugh at the conclusion of this atrocity story. Thus, the social worker is presented as superior to the psychiatrist in terms of assembling a successful cohesive package of care for a severely distressed service user and thus avoiding compulsory admission to hospital through the use of the Mental Health Act.

### **7.3.3.2 Everyone else is a piece of the puzzle and you're at the centre**

The final part of this section will examine another atrocity story which has the same function; namely, to blur a sharp distinction between the social worker and the psychiatrist. This story is from the interview with Andrew.

1 Lisa: And so, did you feel powerful, more power in that role would you  
2 say, than in other?

3 Andrew: Yeah, very much so, more than in anything I've ever done...with  
4 Mental Health Act assessments it's much more focused and umm and it's  
5 much more pressured because it's done under difficult circumstances  
6 often with the police present and all that kind of stuff, you know, so it  
7 just crystallises it more, yes, really

8 Lisa: Yes. And do you find that circumstance when you're there with the  
9 doctors do you feel that you have umm as much say as them?

10 Andrew: I feel I have more say than them

11 Lisa: Why's that?

12 Andrew: Because they umm I think that [pause] again, I've just been  
13 going it for a year

14 Lisa: Yes

15 Andrew: Umm but I think that the doctors seem to invest a lot more in  
16 you. I mean you get the odd one who is a bit gung ho, who'll kind of try  
17 to elbow you out of the way and take over the whole thing and I have no  
18 problem with that because actually I think doctors should be leading the  
19 interview, primarily, but my experience is that they don't, really, it seems  
20 as though everyone looks to you. And I think that's because [long pause]  
21 you were the first point of contact so all the other people involved in the  
22 assessment have spoken to you whereas the doctors will not have  
23 spoken to anybody else really. The doctors won't have spoken to, well,  
24 not very often. They won't have spoken to the police, they weren't have  
25 spoken to the housing officer who's alerted you to it, they won't have  
26 spoken to the local Councillor who has been emailed that someone's  
27 threatened to kill them or something like that. So everyone else is a  
28 piece of the puzzle and you're at the centre of it so when you get there,  
29 everyone looks at you, really, umm and I've actually found that umm I  
30 mean I've been in situations where I've gone I've always clarified with  
31 the doctors beforehand who wants to take the lead on the interview and  
32 they've "oh, I'll do that", but then they get in there and they don't say  
33 anything.

34 Lisa: [laughs]

35 Andrew: So there's this like awkward silence, really. And as you get to  
36 know doctors, I'm quite gobby anyway, really, umm but as you get to  
37 know doctors umm they just get used to that so they so they always

38 seem to look to me to start the interview. I always forget things, there's  
39 always questions that I don't ask, sometimes really important questions  
40 that I don't ask but that's why the doctor's there, you know, so they  
41 jump in, really. So I think that AMHPs are held in very high regard,  
42 particularly by consultant psychiatrists, you know, that's been my  
43 experience anyway.

Andrew characterises the AMHP role as going beyond social work practice in terms of dealing with power issues, requiring additional skills. It involves making decisions in a 'pressured' and difficult environment (line 3-7). Implicit in my next question is an assumption that doctors hold a position with status within the mental health team ['when you're there with the doctors do you feel that you have umm as much say as them?']. Andrew replies that he has 'more say than them' (line 10). Although qualifying his answer that he has only been an AMHP for a year, Andrew portrays the social worker as at the centre of the assessment because 'everyone looks to you' (line 20). Andrew then describes the role of an AMHP in a Mental Health Act assessment (line 21-27). This role is set out in section 13 of the Mental Health Act 1983 as amended by the 2007 Act. It is the responsibility of the AMHP to co-ordinate the assessment and to take all the circumstances of the case into account. Thus, it is the AMHP who will have spoken to the family, any professionals involved, and arranged to meet the two doctors, ideally the GP and a psychiatrist, at the person's home. It is the AMHP who will decide if the police need to be present and organise this if necessary. It is also the AMHP who will arrange an ambulance to convey the person to hospital if the application is made. Andrew encapsulates the central role of the AMHP in the phrase: 'So everyone else is a piece of the puzzle and you're at the centre of it so when you get there, everyone looks at you' (line 27-29). Following the assessment, it is the AMHP who makes the final decision whether to make the application for admission to hospital, founded on the medical recommendations by the doctors. Thus, in fact, the AMHP does have the final power of admission as they can choose not to make the application even if the doctors have completed their recommendations. This is rare but not unheard of.



Andrew then discusses jointly interviewing the person in distress with the doctor(s). Although there is the 'odd one who is a bit gung ho' (line 16), Andrew presents most doctors as taking a secondary role in the interview. He illustrates this with a humorous atrocity story which represents the doctor as rather ludicrous ['they've "oh, I'll do that", but then they get in there and they don't say anything.']. My laughter reflects my bone-fide membership (line 34). Andrew self-description that he is 'quite gobby' (line 36) links with the theme of social workers as assertive found in all of the interviews. Andrew continues to present the doctor as in a secondary role to that of the AMHP ['that's why the doctor's there, you know, so they jump in, really'], reiterating the central status of the AMHP. He concludes the answer with the coda to the stories, that AMHPs are 'held in very high regard, particularly by consultant psychiatrists' (line 41-43). Thus, in this atrocity story, the AMHP is at the centre with everyone else as secondary. As in John's story, Andrew portrays the psychiatrist as somewhat inept and unprofessional.

Next, I ask Andrew if this regard is transferred when working together in the Community Mental Health team.

1 Andrew: Yes, for a very specific reason umm and, but yeah. In particular  
2 when you've got very complicated cases, you know like you were  
3 saying with the CTOs and they're bumping along the bottom and they're  
4 "shall we bring them in, shall we section them, should we, should we not,  
5 should we recall them, shall we give them a bit longer?", they're looking  
6 to you [pause] for those answers really, you know, "well, what would you  
7 do?", you know, "do you think they're sectionable?", you know. Well,  
8 they might be but is it the right thing to do that anyway, you know, umm  
9 quite a lot of people are sectionable actually [laughs] umm but you don't  
10 section them all so why is that. And they look for that discourse from  
11 you, really because ultimately they get all the questions in a Mental  
12 Health Review Tribunal [laughs]

13 Lisa: [laughs]

Andrew illustrates his assertion that social workers are highly regarded by the psychiatrists in the CMHT with a story about a discussion around Community Treatment Orders (CTOs). When there are 'very very complicated cases' (line 2), an

extreme case formulation, the psychiatrist is presented as 'looking to' the social worker for the answers to their questions (line 5-6). Again, Andrew uses active voicing to add a sense of immediacy and richness to the story (line 4-7). In the story, the psychiatrist is presented as asking not one but eight questions which emphasises the point that the social worker is more knowledgeable than the psychiatrist. Humour is also used to present an image of the psychiatrist as somewhat clueless ['umm quite a lot of people are sectionable actually [laughs] umm but you don't section them all so why is that']. Thus, the social worker is shown as having a more sophisticated view of the situation. The reply ends with a joke about the psychiatrist having to prepare for being asked questions in a Mental Health Tribunal by finding out what s/he should say from the social worker ['And they look for that discourse from you, really because ultimately they get all the questions in a Mental Health Review Tribunal [laughs]']. The purpose of a Mental Health Tribunal panel is to review the cases of people detained under the Mental Health Act and to direct discharge where the statutory criteria for detention are not met. The panel comprises a judge and two members, one of which will be a medical specialist. We both laugh here because we are both aware as bona-fide members that psychiatrists tend to be given a tough time by the members of the Tribunal and get asked lots of challenging questions in an adversarial manner. The stories told by Andrew in this section can be seen as examples of an attempt to blur a sharp distinction between the status of the social worker and that of the psychiatrist. In the stories, the AMHP is presented as central to undertaking a Mental Act assessment with superior knowledge to the rather inept psychiatrist who looks to them for advice.

The previous two sections have built upon the work of Dingwall (1977). As in Dingwall's study, atrocity stories were used as an attempt to resolve difficulties of 'exclusion' or 'inclusion'. However, the findings of my study go beyond the telling of atrocity stories about 'others'. In my study, the social workers also told atrocity stories where the nurse was *not* other; and stories where the social worker was other. One example of the latter was Ed's story about the Fitness to Practice cases on the General Social Care Council website discussed in the last chapter in the

section on non-seriousness (section 7.5.1). The following section will examine some more examples of these types of stories.

### **7.3.4 More complex use of atrocity stories**

In addition to the types of atrocity story identified by Dingwall (1977), the social workers in my study used the stories in more complex ways. These included telling stories where the social worker *was* other and stories where the nurse was *not* other. Some of these stories will now be examined, beginning with stories about social workers.

#### **7.3.4.1 She's not a social worker**

In the next extract from the group interview, the AMHP social workers co-narrate a story about the social workers who are employed in the CMHT within the Health Trust. Unusually, the AMHP social workers have remained as employees of the Social Services Department within the Local Authority and not been seconded to the Health Trust. This is an interesting atrocity story because, unlike the stories found by Dingwall (1977), it is not about 'others' in terms of members of other professions. Instead, it is about a group of people who share the same social work profession. Tim introduces the subject.

- 1 Tim: Matt made an interesting observation when we were looking
- 2 through the people the social workers in the CMHT teams I think must of
- 3 thought it was a foregone conclusion that they were going to be the next
- 4 AMHP and they weren't up to standard even though they were qualified
- 5 social workers
  
- 6 Karen: with a lot more experience in mental health than some of us have
- 7 had
  
- 8 Lucy: probably because they have worked in health teams for so long
  
- 9 Tim: because they're steeped in it aren't they?

In this extract, Tim, Karen and Lucy work together to construct a seamless narrative. Tim starts the story and it is then directly extended by Karen's 'with a lot more' and then Lucy's 'probably because' with the coda supplied by Tim's 'because'. Eder (1988) calls this practice 'conjunction', where one long sentence is made by the use of connecting words. Harvey Sacks defined this as 'latching on':

You might think of it as something like a relay race, where two runners come together and the baton is exchanged and one runner continues and the other one stops. (Sacks 1992 vol. 2 p.315)

In this co-narrated story, the CMHT social workers are positioned as somewhat complacently thinking that it is 'a foregone conclusion' that they will be chosen to undertake AMHP training (line 3). However, even though they are 'qualified social workers', they are not 'up to standard' to be able to train as AMHPs (line 4-5). By emphasising that they are *qualified* social workers, Tim is demonstrating just how sub-standard they are because these are the very people who would usually go on to become AMHPs. Tim does not have to elaborate this as our deep competence in being social workers allows us to immediately grasp the point that he is making here. Karen takes over the narration by providing a contrast structure to reinforce the point that Tim has made. The CMHT social workers are deemed as sub-standard even though they have more mental health experience than 'some of us' (line 6). The social workers in the CMHT, the developing narrative suggests, are not able to become AMHPs even though they have *more* experience in mental health. In contrast, Karen has recently qualified as an AMHP despite having *less* experience. Finally, Lucy and Tim co-narrate the coda to the story: the social workers have been based in the CMHT for so long that they have become 'steeped' in the medical model (8-9). Thus, through the atrocity story, Lucy, Karen and Tim elucidate that even social workers can be permeated by the medical model if they are employed by the Health Trust for a period of time. Thus, they are no longer 'real' social workers and so are not able to become AMHPs. The story therefore affirms the decision of this group of AMHPs to remain within the Local Authority rather than be seconded to the Health Trust.

An atrocity story was also used to provide a definition of social work supervision in the next extract. Here a student social worker is the subject of the atrocity story told by a social worker I have called Grace. In response to my first question, Grace has been explaining about how she became a social worker. I comment that she sounds very positive about social work.

1 Grace: Oh massively. Massively. I'm very passionate about when it's  
2 done wrong. I failed a student recently [pause] because she grated every  
3 value base going I'm amazed she got on the course really. Umm [pause]  
4 and I was when I really look at what made me sign off no – yes I was  
5 satisfied that she wasn't meeting the criteria; yes I was satisfied that I  
6 had taken every opportunity to increase her learning and ability. I  
7 increased her supervision. I was seeing her more than I was seeing  
8 clients at one point. It was her value base that was wrong. Completely  
9 wrong. With no demonstration of the importance of understanding what  
10 she was doing that went against every social work value. Err yeah so I  
11 failed her as a result of that and was happy to. Happy to because [pause]  
12 of the thought of a social worker like that practising with vulnerable  
13 people. And I just thought – because I had to jump through quite a  
14 number of hoops before you fail somebody – I thought I'd rather take  
15 what's coming really than have that on my conscience

16 Lisa: I'm glad [laughs]

17 Grace: I was amazed she'd got on the course. It's one of those where you  
18 think "*you should be working on a product because you have no interest.*  
19 *You come to supervision with no reflection or no understanding of the*  
20 *impact of what you're doing, and no concern about what happens to that*  
21 *person when they leave*". And that continued throughout her placement  
22 really

23 Lisa: Right. So if somebody can't develop their thinking

24 Grace: It was umm I think it's easier to to put armour on a vulnerable  
25 practitioner in terms of too much empathy and too much identification.  
26 It's easier to get someone a bit tougher than it is to get somebody who  
27 has no feeling.

Through this atrocity story, the student can be seen as epitomising what social work is not. The student 'grated every value base going' (line 2-3). Grace reiterates this twice more ['It was her value base that was wrong'; 'what she was doing that went

against every social work value'] to emphasise just how lacking the student was in terms of her 'values'. Social work values are a shibboleth of social work and so the student is shown as fundamentally unsuitable to become a social worker.

Even though the student had a great deal of supervision ['I was seeing her more than I was seeing clients at one point'] she is presented as unable to change. Pithouse (1998 p.56) observed that it was through supervision that the skills, attachment to service ideals, and commitment to the shared rationale of new social workers was examined. Grace uses active voicing to report her own thinking and this use of the present tense adds immediacy to her story (line 18-19). The student is described as coming to supervision without the ability to reflect, understand the impact of her practice, and without any concern for the well-being of service users. Therefore, through the device of the story, Grace delineates that supervision is for reflection, developing an awareness of the impact of practice on service users, and for displaying concern for the well-being of service users.

My statements affirm what Grace is accomplishing through the story. My comment shows that I see social work supervision as category bound with the development of thinking ['if somebody can't develop their thinking']. It is interesting that the student is presented as having no value base, interest, concern, or feeling. It is the lack of these *personal* qualities that mean that she is unable to become a social worker. In contrast, a person who is vulnerable, with too much empathy and over-identification is presented as able to become a social worker (line 24-25). Once again, these are personal qualities and thus social work is again presented as somehow intrinsic to the self of its practitioners.

This section has examined the use of stories to delineate 'real' or 'proper' social workers from those social workers who are 'other'. Conversely, the next section will analyse a story where a nurse was *not* other.

#### 7.3.4.2 A nurse as not other

In an interesting apparent ‘deviant case’, a nurse was presented as not ‘other’ in a story told in one of the interviews. In this extract, Grace tells a long narrative about how she acted as supervisor for the first nurse to train as an AMHP in her area. I have asked Grace what she thought about the introduction of the AMHP role. Grace starts her reply to my question by stating that she had a ‘massive view’ about the widening of the AMHP role. She describes the change as a ‘deviation’ and positions social work as the ‘counter balance against the medical model’. She continued:

1 Grace: So to challenge my own thoughts I took the first nursing student  
2 who went through in the Trust. Me and his social worker did and if I’m  
3 being really fair and it’s uncomfortable to admit it I gave it so much  
4 rigour in one way or another. I put that guy through the wringer [laughs]

5 Lisa: [laughs]

6 Grace: I really did and he was amazing. I passed him and he was great.  
7 And now he’s left the Trust and he’s doing AMHP work [in another area].  
8 But again, you know, when I interviewed when I was part of the process  
9 of that I picked him because of when you listened to him he really if  
10 anything he was too least restrictive. He was so aware of so many  
11 psychosocial stressors, the impact of this on families, it was just he was  
12 like a social worker. And the way that he conducted assessments and  
13 how he approached people was just [pause] amazing it was just and he  
14 wanted to, you know, he wanted to learn, he was interested in it, he  
15 respected the authority, he respected the role of an AMHP and it just  
16 oozed from him [] And watching him – because obviously he’d never  
17 involved with an assessment – seeing him do that and when he came out  
18 with me once he made a mistake about something and I said “*no you*  
19 *should have done that*” and he said he was really cross that he’d done  
20 that, you know. And what he wrote was brilliant so brilliant

21 Lisa: So good and you challenged your own perceptions there

22 Grace: I did. I thought I really should have a go at this just to see what I  
23 feel.

Here Grace tells a long narrative about how she acted as a practice educator for the first nursing AMHP student in her Trust in order to ‘challenge my own thoughts’ (line

1). Here we both laugh at a nurse-as-other being put through 'the wringer' (line 4). However, in contrast to the student social worker she described earlier, Grace passed the nurse (line 6). He is described as 'amazing' and 'great' (line 6). This might appear contrary to the predominant view within the interviews which positions the nurse as other. However, Grace goes on to depict the nurse as 'like a social worker' in that he was not 'restrictive', 'so aware of so many psychosocial stressors', and aware of the impact of mental distress on families (line 11-12). This characterisation achieves two things: firstly, the nurse is *not other* because he is like a social worker; and secondly, it provides a definition of social work (namely, social work as being least restrictive and about having an awareness of psychosocial stressors and the impact of this on families). The nurse student is also described as 'amazing' (line 13) in how he approached assessments and people, and that he respected the authority and role of an AMHP. Again, these are qualities would be expected from a social worker as I recognise through unique adequacy. Grace uses the phrase 'it just oozed from him' (line 16) which evokes an image that these qualities are somehow fundamental to the *personal* identity of the nurse. The nurse is also positioned as taking on board that the social work interpretation was correct ['I said "*no you should have done that*"'] and being contrite ['he was really cross that he'd done that']. My next question asks Grace for some information about the nurses that she interviewed to become her AMHP student.

1 Lisa: So did you interview other people that you didn't obviously you  
2 chose him why didn't you choose them?

3 Grace: Because they were very very reluctant to move away from a  
4 medical model, they were very very authoritarian, they were very one-  
5 sided, they were very reluctant even to consider, you couldn't shake  
6 them off it was just [pause] yeah that role was seen as something to  
7 enhance their career whereas my guy was talking about the roles and  
8 responsibilities that came with it, how interested he was in that and  
9 came with a different value base. I want to progress my career, we all do,  
10 but that's not the only when I move up a gear each time I want to  
11 enhance what I'm doing as a result of that for service users and other  
12 staff not just for my own narrow and I think with the ones I interviewed  
13 it was very much about their own career pathway and I think pathways



14 are important it's not just one path. It shouldn't just be one thing. There  
15 should be things parallel with that. It's not just about you. It can't be  
16 about you only

17 Lisa: No because that role is hugely about the value base

18 Grace: Totally

19 Lisa: It's not just a role that you do, is it?

20 Grace: He was just he was agonising over things and you'd never think of  
21 it from a well from a nurse to that degree [] and he so wanted to get it  
22 right – for them. Not like the student social worker that wanted to pass  
23 for her. There was no consideration. It was just me, me, me whereas this  
24 one was *“if I get this wrong, if I get this wrong in real life in practice and*  
25 *the impact that has on people”*, you know, especially where there was  
26 children around and that had quite a profound for him. And that's what  
27 you want – range.

In contrast with the nurse trainee, the nurses that Grace did not choose are described in a very different way. They were 'very very reluctant to move away from a medical model, they were very very authoritarian, they were very one-sided' (line 3-5). Here the repeat of the word 'very' is an extreme case formulation (Pomerantz 1986) and is used to demonstrate the degree of the difference between these nurses and her nurse student. The description positions these nurses as other: as subsumed within the medical model, as authoritarian, and as only wanting to undertake the AMHP role for career development. Grace directly contrasts these nurses with 'my guy', a description which positions him as identified with Grace (line 7). He 'came with a different value base' (line 9). Grace then contrasts her wish to develop her own career in order to enhance the lives of service users and staff members with that of the nurses she interviewed (line 9-11) The nurses are described as having 'narrow' and self-serving reasons for career progression ['It's not just about you. It can't be about you only'].

My two comments display my competency in the social work trade: that AMHP work is predicated on social work values and is more than a functional role (line 17 and 19). Grace's reply shows her recognition of this by describing the nurse as a 'proper'

AMHP [‘He was just he was agonising over things and you’d never think of it from a well from a nurse to that degree’]. Here the nurse is not a ‘proper’ nurse because he was ‘agonising’ over his decision-making. Finally, Grace contrasts this nurse with the student social worker she had discussed earlier in the interview (examined above). The focus for the nurse is on the impact on service users and the use of active voicing shows just how ‘profound’ this was for him [‘this one was “*if I get this wrong, if I get this wrong in real life in practice and the impact that has on people*”’]. In contrast, the student social worker is focused on her own needs [‘There was no consideration. It was just me, me, me’]. This is a very interesting story because a nurse is presented as ‘better’ than a social worker. However, the nurse is ‘just like a social worker’ and the student social worker is presented as unlike a social worker. Thus, both are atypical and so do not undermine the practice of atrocity stories to present the ‘occupation members as hero’ (Dingwall 1977 p.30).

This section has been concerned with very artful tellings of an atrocity stories. The social workers were able to use these stories in much more complex ways than those identified by Dingwall (1977). The final part of this chapter will now turn to the concept of ‘co-narration’ in the telling of atrocity stories.

#### **7.4 Atrocity stories and co-narration**

The work of Donna Eder on ‘cohesive narration’ will be used to inform this section. Eder (1988) examined collaborative personal narratives among adolescent girls. She defined collaborative talk as where an utterance supports or ratifies the previous utterance in some manner. Eder (1988) found that when two or more people are involved in generating a narrative, they not only need to maintain the coherence of the narration but also need to connect turns at talk. The girls in Eder’s (1988) study used a range of strategies to collaborate in narrating the talk in a coherent manner. For example, co-narrators tended to repeat other speakers’ words and phrases in order to emphasise their importance as well as their legitimacy. Eder (1988)

concluded that collaborative storytelling was an important means of conveying cohesiveness within the group of girls.

Eder (1988) observed that the highest degree of collaboration was found in a stable friendship group of girls who based many of their narratives on their shared experiences of belonging to a choir. She argued that being a member of the choir gave the girls the necessary background knowledge to participate in stories about choir events. Indeed, Eder found that occasionally the girls told stories which were so highly collaborative that there was no main narrator. Eder (1988) concluded that:

A high level of shared experience and perceptions is necessary to produce such collaborative talk, but this production strengthens and establishes greater cohesiveness among the participants. (Eder 1988 p.230)

Thus, for Eder, co-narration is seen as both *a result of* shared experiences and also *as increasing* this sense of cohesiveness. While not examining atrocity stories per se, Eder found that group solidarity was increased where the subject of a story was a girl who was not a member of the choir. Eder (1988 p.230) concluded that by 'expressing a negative, shared perception of an outsider, group members imply the existence of positive, shared feelings among themselves'. The work of Eder will be used to examine some of the co-narrated atrocity stories found in my data.

#### **7.4.1.1 A story about number clusters and nut clusters**

Several co-narrated atrocity stories were told during the group interview. As a group of AMHPs, the members of the group all shared the same social work identity and thus were 'cultural colleagues'. Taylor and White (2000) argued that:

...when only one professional group is involved in the talk...a process of co-narration, where different speakers "chip in" with affirming statements, reinforces the rhetorical force of what is a partial reading of a case. (Taylor and White 2000 p.122)

Co-narration can be found throughout this excerpt which I have called the 'nut cluster' narrative. Consider the opening statements:

- 1 Tim: I believe that health have got this commitment it's there but you're
- 2 talking numbers now it's like what do they call it?
- 3 John: the clustering
- 4 Lucy: they cluster people.

Here John and Lucy are referring to a 'Mental Health Care Cluster'. This is defined in the NHS Data Model and Dictionary Service as 'a type of category valued person observation'. The definition continues:

[It is] part of a currency developed to support Payment by Results for Mental Health Services. Mental Health Care Clusters are 21 groupings of Mental Health patients based on their characteristics, and are a way of classifying individuals utilising Mental Health Services that forms the basis for payment... assigned using a decision tree or algorithm based on the person score from the Mental Health Clustering Tool undertaken by a care professional for the patient.

The use of language in this definition can be seen as being firmly placed within the scientific and medical model. The 'patient' is 'classified' based on 'their characteristics' and then 'assigned using a decision tree or algorithm' to one of 21 'groupings'. The language can be seen as very different to that of social work as Lucy demonstrates when she continues:

- 1 Lucy: It's like, you know, how can you work with that? It's putting people
- 2 into frameworks and it doesn't move does it really? I mean some of the
- 3 people we work with in the community they've ended up sectioned or
- 4 detained after a Mental Health Act assessment because of the support
- 5 that they got from the assertive outreach team. If it was more fluid, if
- 6 there were more social inclusion and more engagement because that's
- 7 what that's about really and you know using that as a pathway to
- 8 recovery alongside treatment as well and it's that that's not there really.
- 9 They might get allocated one hour once a week or once a fortnight and
- 10 it's not enough. And it falls down, it comes to our door via care
- 11 management to go out and do an assessment to see if we can put in a
- 12 package of support really to what health should have been doing. And if
- 13 we were to start saying yes to them the worry is that we open the

14 floodgates and we get more and more of this it's just health's failings  
15 really.

In contrast to the medical and scientific language of 'clustering', Lucy uses social work language such as 'social inclusion', 'engagement' and 'recovery' (line 6 and 8). The use of specialised vocabulary and technical language conveys expertise. In using such language, Lucy exhibits her social competence in accomplishing social work through her talk. In turn, shared background expectancies mean that the other members of the focus group recognise this as social work talk, as do I. In her account, Lucy directly contrasts the work of the health-led assertive outreach team with that of the social work team. The assertive outreach team is presented as not fluid or engaged with service users, only offering one hour of support a week (line 5-9). This 'is not enough' (line 10) and the service user ends up being 'sectioned or detained' in hospital (line 3-4). This emphasis on *formal admission* after a Mental Health Act assessment, rather than *informal admission*, adds weight to Lucy's assertion that the assertive outreach team is lacking and not fulfilling its remit of preventing admission. The social work team is presented as having to resolve 'health's failings' (line 14) by putting in 'a package of support really to what health should have been doing' (line 12). In this atrocity story, the social work team is portrayed as having to resolve the failings of health's assertive outreach team. It is only the social work team that is able to support service users and prevent formal admission to hospital. My response displays my social work identity through my recognition of what the story is accomplishing.

1 Lisa: But it's almost that they're failing at their role really

2 Tim: through numbers yeah. Failure through numbers. That'd be a good  
3 name for your report [all laugh]

4 Lisa: [laughs] Thank you. But that's awful isn't it because they are the  
5 mental health teams

6 Isobel: well it's the same as CPNs taking them off their case load and  
7 closing cases

8 John: just highlighting one case, a care officer who did a good job with  
9 the client but it was taken off as it he was too complex for her and I was  
10 saying I think it should be back with her "*I don't know because what's he*  
11 *clustered at what's he clustered at?*" They were putting the cluster  
12 before the client or as they would call them, the patient. "*Oh they can*  
13 *have that because he's clustered at seventeen*". That's totally wrong.  
14 That's cart before the horse, every time.

My mirroring of Lucy's word 'failing' in my comment exhibits my understanding of the story (line 1). Tim continues by extending my sentence in a co-narration ['through numbers yeah']. The use of humour and shared laughter (line 3-4) can be seen as both reflecting and contributing to a process of bonding as members of the same profession. Tim orientates the group to the interview situation by referring to my 'report', as discussed earlier in section 7.6. Although I laugh, it is noticeable that I immediately attempt to re-orientate the discussion back to the narrative with the phrase 'But that's awful isn't it' (line 4-5). The use of the word 'But' demonstrates that I am deviating from the 'preferred response' by not making a sequential response to Tim's statement. Tim's phrase 'Failure through numbers' alludes to the earlier discussion about clustering and people being categorised as numbers. John picks up on this and tells an atrocity story which shows the failings of health in relation to service users (line 8-14). It is significant here that the care officer who is doing a 'good job' (line 8) is a Social Service employee seconded to the Health Trust and so is aligned with the social workers. The use of active voicing here adds dramaturgical interest. John does not even have to specify who is 'speaking' here; as bona-fide members it is clear to us all that 'they' is a health professional (line 11-12). Using the pronoun 'they' can be seen as a distancing device: it polarises two groups in terms of 'we' and 'them'. Additionally, by using the general term 'they' rather than assigning the reported speech to one named individual, this perspective can then be attributed to a collective group of people, namely health professionals in general. This allows the speaker to epitomise a group through the characteristic utterances of the 'prototypical group member' (Buttny 1997 p.499).

John makes a direct contrast between the social work term 'client' and the health term 'patient' (line 12). The differing use of language displays the fundamental distinction in the approach to mental health service users as outlined by Tew (2011 p.9) Here Care Cluster 17 [*"he's clustered at seventeen"*] is defined in the Mental Health Clustering Tool as 'Psychosis and Affective Disorder (Difficult to Engage)'. Again, this is very psychiatric medical language. Once again, my taken for granted knowledge and background expectancies means that I recognise that clustering at seventeen would attract enough funding to have a care officer allocated to the case. As social workers we 'share a common stock of occupational assumptions... confident that the other... is able to gather the implicit meanings and draw appropriate inferences' (Pithouse and Atkinson 1998 p.193).

Finally, the phrase 'putting the cluster before the client' mirrors the English proverb 'putting the cart before the horse' which John then uses as the coda to the story. Health are therefore positioned as reversing the right way of doing things – i.e. the social work way. The moral of this atrocity story is that there is a clear difference in the approach to service users: health professionals erroneously see people in terms of numbers and categories and only social workers can see that this is a reversal of the right approach. Isobel continues the discussion:

- 1 Isobel: it's more gate keeping
- 2 Lucy: it is
- 3 Isobel: you only like nut clusters don't you?
- 4 Lisa: Not the number clusters [all laugh].

Isobel and Lucy's statements affirm that they recognise what John is accomplishing through the story. The narrative ends with humour and shared laughter, also affirming our shared social work identity. My co-narration of the joke reveals my deep competence in the haecceity or the 'just thisness' of the social work trade (ten Have 2004 p.22).

Co-narration is also accomplished in the next extract from an individual interview with an AMHP that I have called Ed.

#### 7.4.1.2 A story concerning crisps

Once again, it is a social worker that is the subject of the atrocity story. Here Ed and I co-narrate a story about a social worker in a TV show.

- 1 Ed: Social workers did you ever see that documentary? You must have  
2 seen that documentary exposure
- 3 Lisa: Yes
- 4 Ed: which was fixed a bit because the guy had. There was this brilliant  
5 footage I mean even I had to admire it's kind of like [laughs] how set up  
6 this was and it was this woman sitting at a desk eating
- 7 Lisa: Crisps
- 8 Ed: a bag of crisps with her feet up
- 9 Lisa: And saying "*I don't want to go out*"
- 10 Ed: "*Because the houses smell of piss*". And I thought that is how a lot of  
11 people that's what they think social workers do
- 12 Lisa: I know. That image will never leave my mind
- 13 Ed: It will never leave *my* mind
- 14 Lisa: I knew you were going to say that because that is the image that  
15 just stays with you
- 16 Ed: That image because I was just watching it and I just thought "*no,*  
17 *man*" because they couldn't have set this up they couldn't have  
18 promoted more negative images than this woman, this silhouette,  
19 slightly overweight, eating crisps, talking about how people's houses  
20 smell of piss
- 21 [both laugh]
- 22 Ed: You know "*I don't want to do that*". And they are never going to  
23 promote that. Because that is what we are to a lot of people.



The telling of this atrocity story displays our concerted ongoing accomplishment in a number of ways. Firstly, our shared background expectancies are established through Ed's statement that 'you must have seen that documentary' and my affirmation (line 2-3). Ed assumes that I 'must' have seen the show and thus supplies no further details of this documentary. However, I immediately recognise that he is referring to a particular documentary about a child protection social work team. This was a Channel 4 documentary called 'Undercover Social Worker' (Mathieson 2010) in which a reporter worked covertly in a UK social services department for three months. Again this exchange is an example of the documentary method of interpretation. As in the Dana story, we both understood Ed's reference not only from what he actually said but what was left unspoken. Ed does not have to elaborate here but pre-supposes that I share this common scheme of interpretation. It is also interesting here that we both share the same overriding image from the documentary: a female social worker sitting at her desk eating crisps (line 6-8). My statement 'That image will never leave my mind' is directly mirrored by Ed's 'It will never leave *my* mind' (line 12-13). Eder (1988) identified that this repetition of a word or phrase supports or ratifies the previous utterance.

Ed and I co-narrate the whole story. Even though we have never met before, Ed and I are able to produce a seamless narrative. I complete his first sentence ['eating... Crisps'] and Ed then extends the sentence further ['a bag of crisps with her feet up']. Finally, we continue to extend the sentence through the use of conjunctives ['And' and 'Because']. Through these devices we are able to work together to produce a continuous sentence. Significantly, my findings differs from Eder's (1988) conclusion that the girls were able to produce collaborative narration due to being a stable peer group who had known each for a long time through being at the same school and members of the same choir. I had never met or spoken to Ed before this interview and our email correspondence was limited to the logistics of arranging the meeting. To me, then, this exchange powerfully demonstrates the depth of our shared competence in the haecceity of social work.

Even though Ed is at pains to point out that the documentary was ‘fixed a bit’ and ‘how set up this was’ (lines 4-6), he acknowledges ‘that is how a lot of people that’s what they think social workers do’ (line 10-11). Through this story, Ed and I portray the negative image of social work and how social work is represented by the media [‘they couldn’t have promoted more negative images’]. This echoes the findings of the Final Report of the Social Work Taskforce (2009 p.48) that the ‘public image of the profession seems therefore to be unremittingly negative’.

In our story, the social worker epitomises this negative perception of social work. As well as co-narration, our vulgar competence is also displayed through the use of humour. We both laugh at the extremely negative image of ‘this woman this silhouette, slightly overweight, eating crisps, talking about how people’s houses, smelling of piss’ (line 18-19). This is another example of how gallows (White 2006) and bleak (Pithouse 1998) humour can be used to support identity claims. Thus, although the ‘other’ in this atrocity story shares the same social work profession, the story still works to reinforce our collective identity. Like the social worker in the Fitness to Practice case Ed discussed earlier (see section 7.5.1) the woman in the documentary is not a ‘real’ social worker. Once again, our laughter (line 21) works to demonstrate this disaffiliation and establish our competency as group members.

## **7.5 Conclusion to Chapter**

To conclude, the social workers in this study produced a large number of atrocity stories within the interviews. Several of these stories have been examined in depth in this chapter using an ethnomethodological approach. Like the health visitors in Dingwall’s (1977) study and the nurses in Allen’s (2001) research, the social workers can be seen as occupying a marginal position within the CMHT and the stories they tell interpreted as a form of boundary work with those professionals where there is an overlap in jurisdiction.

However, there are three ways in which the stories discussed in this chapter can be seen as extending the findings of previous research in this area. Firstly, atrocity stories were told about those sharing the same profession. In the work by Stimson and Webb (1975), Dingwall (1977), Baruch (1981), and Allen (2001), the stories were about 'others'. In this study, the AMHPs told stories about other social workers. However, this was accomplished in a very artful way as these social workers were presented as not 'real' social workers. For example, the CMHT social workers were shown to be not 'proper' social workers by the members of the group interview.

Secondly, in an apparent deviant case, a member of the 'other' was presented in a positive light in a story and indeed as superior to a member of the same profession. So in the stories told by Grace, the nurse AMHP was presented as better than the student social worker. However, both the nurse and the social work student are atypical: he is like a social worker and she is not a 'real' social worker. Again, this is a very artful telling in which the practice of atrocity stories to present the 'occupation members as hero' (Dingwall 1977 p.30) is maintained.

The third extension is to previous research on co-narration. My findings differ from Eder's (1988) conclusion that the girls were able to produce collaborative narration due to being part of a long-standing peer group. In my study, co-narration was successfully accomplished by two 'strangers' but who are 'cultural colleagues'. It is a powerful demonstration of the competencies involved in being a 'bona-fide' member of a collectivity. Sharing a social work identity with my participants gives me unique adequacy and allows for the taken for granted components to be displayed in our interaction. In the interviews, then, we do being a social worker.

## 8 Conclusion

### 8.1 Accomplishing social work identity

When I began this research project in the Professor's office almost four years ago, I had no idea of the 'ups and downs or twists and turns' that would be involved (Leigh 2013b p.261). When setting out to explore social work identity, I did not envision what a profound effect the research would have on my own identity as a social worker. However, rather than attempt to hide these twists and turns, I think that it is important to acknowledge and openly discuss the impact they have had on my social work identity. After all, social work identity is the very subject matter of this thesis. In particular, being a member researching my own 'group' has had particular consequences, not least the uncomfortable feeling of having a 'dirty secret' that has been an unwelcome, if necessary, accompaniment to the research process. Initially meeting the unique adequacy requirement of methods may have been easy as a group 'insider' but the difficulties began as the commonplace and unnoticed were 'breached'. Like the experiments Garfinkel (1967 p.38) devised for his students as 'aids to a sluggish imagination', undertaking the research has caused me bewilderment and anxiety. However, I can certainly conclude that, in this aspect, the research has been truly ethnomethodological.

The resolution of these difficulties has been to present the findings of the study in a way that mirrors the research journey. The first half, 'Being a Social Worker', began with a presentation of the themes that emerged from the interviews with the social workers. Here the focus was on the interviews *as a resource* and so this was a more traditional reporting of *what* the social workers talked about in the interviews. The objective here was to present 'being a social worker' from the participants' point of view using thick description (Geertz 1978). Chapter 4 showed how the social workers worked to delineate 'real' or 'proper' social work. Specifically, the 'authentic realm of social work' (Pithouse 1998 p.21) was depicted as involving social change and autonomous work in the community with mental health service users. In contrast,

the social workers had a negative view of other demands on their time, in particular bureaucratic requirements, as this took them away from what they considered as the real work. The contrast between the real and the other work was usefully summarised by Eva as the 'treasured' and the 'rubbish'. Chapter 4 was also concerned with 'being a real social worker'. Here social work identity was portrayed as intrinsic to the self with congruence between personal identity and values and social work identity and values. This was illustrated by a detailed analysis of the interviews with Andrew and John. The social workers contrasted key people who epitomised 'real' social work from social workers whose social work identity was non-genuine. However, the social workers struggled to define social work. Instead of having a clearly defined role, social work was depicted as intangible, as being without clear margins and boundaries, and filling in the gaps left by other professions. Finally, it was contended that social work students can be seen as 'marginal natives' and that their marginality requires social workers to leave the natural attitude in order to make social work visible.

The following chapter built upon this theme of real social work. It was argued in Chapter 5, 'Being an Approved Mental Health Professional', that AMHP work exemplified real social work. Specifically, AMHP work was 'real' social work because it encompassed being autonomous, managing complex situations in the least restrictive manner, and being assertive on behalf of service users. Thus, far from being designated by the social workers as 'dirty' or 'shit' work (Hughes 1948; Emerson and Pollner 1975), being on AMHP duty was seen as prestigious, requiring advanced skills, and the ability to manage very complex situations. However, it was clear that AMHP duty holds an inherent ambiguity. Although the social workers did not designate the act of detention as dirty work that was not to say that they did not find the role difficult or uncomfortable. The work clearly contained tensions and ambiguities and being an AMHP on duty is emotionally difficult and mentally draining. The negative aspects of the role were an integral part of the stories that the social workers told about the work.

The second half of Chapter 5 was concerned with AMHP work in the more general sense of 'being a social worker in a mental health team'. It was argued that, by being in a Mental Health Trust, the social workers were unable to make social work 'visibly-rational-and-reportable-for-all-practical-purposes' (Garfinkel 1967 p.vii). The social workers were isolated within predominantly health teams with weak links to their Local Authority employers. In addition, many of the social workers were unable to make social work visible through supervision (Pithouse 1984) as they were being managed and supervised by health professionals. Chapter 5 concluded with a discussion of the main themes from the interviews concerning the introduction of the AMHP role. In their stories, the social workers positioned nurses as the 'other' and it was through these contrasts that the social workers depicted what was real social work. Furthermore, the social workers also identified the introduction of the AMHP role as a step in the demise of mental health social work.

In many ways, the analysis presented in Chapters 3 and 4 was beginning to be crystallised once I had completed the data collection stage. Of course, at that time, my ideas about social work identity were very tentative and unformed and it was not until undertaking the process of analysis that the themes emerged in the depth that they have been presented in this thesis. However, this was exactly the kind of analysis and writing that I had expected to include in the final thesis. After all, this was what a standard interview analysis entailed. What was completely unexpected was the part that I played in the data, as has been detailed in Chapter 2. Specifically, by my being a group member, the interviews can be seen as a representation of the accomplishment of social work identity in action. Unlike a researcher who has to meet the unique adequacy requirement of methods in the weak sense prior to or during the research process, as a social work member with over ten years post-qualifying experience, I was already 'vulgarly competent' (Garfinkel and Wieder 1992) and naturally accomplished doing being a social worker in the research interviews. Indeed, during the fieldwork stage, this was so natural that the accomplishment was unconscious.

Thus, the analytic focus shifted in the second part of the findings chapters from the interview *as a resource* to the interview *as a topic*. In this part, 'Doing Being a Social Worker, ethnomethodological and conversation analysis were employed to understand *how* social work identity was accomplished *within the interview interaction*. Following an overview of the use of ethnomethodology and conversation analysis in social work research, the practical and emotional implications of being a member were discussed (Chapter 7). Attention then turned to the use of non-seriousness within the interviews. Building on the work of Pithouse (1998) and White (2006), it was argued that ironic banter about the other and the use of gallows or bleak humour worked to accomplish affiliation between 'bona-fide' members of a collectivity (ten Have 2007 p.140) and disaffiliation with other, non-genuine social workers. It became apparent through the analysis was that the laughter, irony, sarcasm and hyperbole were a joint accomplishment. Moreover, it was argued that unique adequacy, vulgar competence and indexicality all play a crucial part in the joint accomplishment of non-seriousness. Finally, building on the work of Holt (2013), the inextricable interdependence of seriousness and non-seriousness was demonstrated. This was particularly evident in the telling of troubles (Jefferson 1984) and in the two examples where there was a breach in the production or negotiation of non-seriousness.

The final section of Chapter 7 was concerned with the ways the interaction was produced and managed *as a research interview*. Drawing upon the work of ethnomethodology and conversation analysis, the focus was on the 'haecceities, the just thisness' (Garfinkel and Wieder 1992 p.203) of the interview encounter. Here the analysis demonstrated that the interaction 'comes off' (Sacks 1992 Vol. 2 p.11) as a research interview through such devices as 'adjacency pairs' (Sacks 1992) and 'preferred' and 'dispreferred' responses (Pomerantz 1984). It was argued that there were subtle ways in which the asymmetrical relationship of an interview encounter was artfully managed by both parties in the interaction.

The final Chapter of the thesis examined how the telling of atrocity stories was a prevalent way in which social work identity was accomplished in the interviews. Like the health visitors in Dingwall's (1977) study and the nurses in Allen's (2001) research, the social workers in my project can be seen as occupying a marginal position within the Community Mental Health team and the stories they told interpreted as a form of boundary work with those professionals where there is an overlap in jurisdiction. However, there are three ways in which the atrocity stories discussed in Chapter 8 can be seen as extending the findings of previous research in this area. First, in the work by Stimson and Webb (1975), Dingwall (1977), Baruch (1981), and Allen (2001), the stories were about 'others'. In contrast, in my project, the atrocity stories were told about other social workers. However, this was accomplished in very artful ways as the social workers in the atrocity stories were presented as not 'real' social workers. Second, in an apparent deviant case, a member of the category 'other' was presented in a positive light in a story and indeed was depicted as superior to a member of the social work profession. So in the stories told by Grace, the nurse AMHP was presented as a better practitioner than the student social worker. However, both the nurse and the social work student are atypical: he was 'like a social worker' and she was not a 'real' social worker. Again, this was a very artful telling in which the practice of atrocity stories to present the 'occupation members as hero' (Dingwall 1977 p.30) was maintained. The third extension is to previous research on co-narration. My findings differ from Eder's (1988) conclusion that the girls were able to produce collaborative narration due to being part of a long-standing peer group. In my study, co-narration was successfully accomplished by two 'strangers' but who are 'cultural colleagues'. This was a powerful demonstration of the competencies involved in being a 'bona-fide' member of a collectivity. Sharing a social work identity with my participants allowed for the taken for granted components to be displayed in our interaction. In the interviews, then, we 'do being a social worker'.



## 8.2 Reflections on the use of ethnomethodology in the research process

Insights gained from ethnomethodology have played a significant part in the research process. In particular, being a vulgarly competent *member* has been intrinsic to the analysis of the interviews. Other EM notions such as indexicality and the documentary method of interpretation have also been important in making sense of the interview talk. The use of ethnomethodology has enabled me to make visible the 'seen but unnoticed' (Garfinkel 1967) aspects of doing being a social worker. Indeed, ethnomethodology enabled me to answer my original research question about being '*such a social worker*' or, conversely, '*so not a social worker*'. This has given me the ability to describe social work practice differently; an ability which can now be used fruitfully to initiate discussion with social work students and practitioners in my new role as a social work academic. However, as discussed earlier, I found it impossible to meet the unique adequacy requirement of methods in the *strong use*. Whilst every attempt was made to use ethnomethodological indifference in the sense of not judging the 'adequacy, value, importance, necessity, practicality, success or consequentiality' (Garfinkel and Sacks 1970 p.166) of the accounts of social workers, I did not focus solely on members' methods. Instead, concepts were imported from the 'corpus of classic methods and findings' from professional sociology (Garfinkel 2002 p.170) in order to analyse the interview data. For example, I used the findings of Emerson and Pollner (1975) to explore the concept of 'dirty work'. Thus, whilst it was necessary to take a normative position in order to review other studies from social work research that used ethnomethodology (Chapter 5), it is important to acknowledge that I also did not meet the requirements of 'pure' ethnomethodology. Thus, it is more accurate to describe my work as benefitting from ethnomethodological insights.

### 8.3 Limitations

The primary limitation of this study is that it is based on interviews rather than on 'naturally occurring' data. Ethnomethodological research has tended to concentrate on 'naturally occurring' data and has rarely used interviewing as a method of data collection or interviews as a source of data. In addition, it is notable that the studies that have played a significant part in my understanding of my data have been ethnographies (in particular, the work of Andrew Pithouse and Sue White). In situating my work alongside these studies, it is important to acknowledge these methodological differences.

However, there is a growing body of ethnomethodological writing on interview talk (for example, Cicourel 1964, Hester and Francis 1994, Rapley 2001, and Baker 2003; 2004). Moreover, rather than attempting to gloss over the source of data, there has been an concern with demonstrating the haecceity, the 'just thisness' (Garfinkel and Wieder 1992 p.203) of the research interviews by describing the accomplishment of the interview 'as it is interactionally and collaboratively achieved by the interviewer and interviewee *in this case*' (Hester and Francis 1994 p.681).

The subjective nature of the research process presented in this thesis may also be seen as a limitation by some more positivistically-minded researchers - or even other 'realist' qualitative researchers. Indeed, I recall being told in a teaching session on 'qualitative research' that the first step in analysis was to remove all the questions asked by the researcher. I do not wish to deny the part that I played in the interaction. Indeed, ethnomethodological and conversation analysis is concerned with members in an interaction. However, it is important to acknowledge that, as a social work group member, there may be times when I have not achieved the 'distance' described by Hammersley and Atkinson (2007 p.90). Hopefully, having a non-social work supervisor for the final year of my doctorate has helped to create distance from the unseen elements of being a member. In addition, several deviant cases and notable 'disjunctures' which occurred during the interview interactions

have been examined in order to enhance the credibility of the project. Ultimately, in accordance with the commitment to fallibilistic open-minded debate advocated by Seale (2007), it is for an external audience to judge.

## **8.4 Conclusions**

The aim of this thesis has been to explore how social workers seconded to Health Trusts accomplish a social work identity. Like Wieder's (1974) seminal study, this has been presented in two parts: an overview of the setting followed by a detailed analysis of how this was accomplished. Thus, the first part of this thesis has provided an overview of the settings in which social workers attempt to accomplish a social work identity. Thus, the themes that emerged from the interviews about being a social worker in a Mental Health Trust have been presented. These show the immense pressures that this group of social workers were facing. The social workers were isolated, spending most of their time unable to engage in what they considered to be real social work. Whilst AMHP work was seen as prestigious, many aspects of the role had inherent ambiguities and being an AMHP on duty was emotionally difficult and mentally draining. This world is generally invisible to those outside social work. As the original literature review showed, there are very few studies in which these issues are portrayed.

Again following Wieder (1974), the second part of this thesis has been concerned with using ethnomethodology and conversation analysis to show how social work identity was actually accomplished within the interview as interaction. Social work identity was accomplished through members' methods such as the use of humour and laughter and the telling of atrocity stories. Again, this world of mental health social workers is rendered invisible in much ethnomethodological and conversational analytical social work research. This study seeks to sit alongside other ethnomethodological and conversational analytical focused investigations of social work identity and occupational practices and to extend this knowledge to include mental health social work.

## Appendix One: Protocol for scoping review

### **Keywords:**

social work\* AND  
mental health\* AND  
interprofessional\* OR inter-professional\* OR inter professional\* OR interagenc\* OR  
inter-agenc\* OR inter agency OR interdisciplinary\* OR inter-disciplinar\* OR inter  
disciplinar\* OR multi-disciplinar\* OR multidisciplinar\* OR partnership\* OR multi-  
professional\* AND  
identit\*

### **Inclusion Criteria**

Written in English  
Research conducted in the UK  
Published from 1 January 1990 onwards

### **Exclusion Criteria**

Language other than English  
Research conducted outside the UK  
Published prior to 1990

### **Databases to be searched**

Academic Search Premier; Applied Social Sciences Index and Abstracts; Care  
Knowledge; CINAHL (EBSCO); MEDLINE (OVID); PsycINFO; ScienceDirect (Elsevier);  
SCOPUS; Sociological Abstracts (CSA); Social Care Online; Social Services Abstracts;  
Swetswise; Web of Knowledge (ISI); Wiley

### **Search for Grey Literature**

BASW; Centre for Mental Health; DART- Europe E-theses Portal; Department of  
Health; EthOS; General Social Care Council; Google Scholar; Intute: Social Sciences;  
Mental Health Alliance; Mental Health in Higher Education (mhhe); MIND; Social  
Care Online (SCIE); Social Perspectives Network; Social Services Research Group  
(SSRG); Social Science Research Network; System for Information on Grey Literature  
in Europe Archive (SIGLE); Web of Science with Conference Proceedings (ISI)

### **Hand search of key journals**

British Journal of Social Work; Journal of Interprofessional Care; Journal of Social  
Work; Qualitative Social Work

### **Citation search of key articles**

The citations of key articles will be searched using the ancestry approach.

**Author search**

If an author is identified as writing key articles, then I will search for his/her other work, including work-in-progress, using the Web of Knowledge (ISI) database.

## Appendix Two: Protocol for Literature Review

1. Keywords  
sw\* AND mh\* AND interprofessional\* OR inter-professional\* OR inter professional\* in all fields
2. sw\* AND mh\* AND interprofessional\* OR inter-professional\* OR inter professional\* in abstract
3. sw\* AND mh\* AND interprofessional\* OR inter-professional\* OR “inter professional\*” in subject terms
4. sw\* AND mh\* AND interagenc\* OR inter-agenc\* OR “inter agenc\*” in subject terms
5. sw\* AND mh\* AND interdisciplinary\* OR inter-disciplinar\* OR “inter disciplinar\*” in subject terms
6. sw\* AND mh\* AND multidisciplinary\* OR multi-disciplinar\* in subject terms
7. sw\* AND mh\* AND partnership\* in subject terms
8. sw\* AND mh\* AND multi-professional\*\* in subject terms
9. sw\* AND mh\* AND identit\* in subject terms

### **Inclusion Criteria**

Written in English

Published from 1 January 1990 onwards

### **Exclusion Criteria**

Language other than English

Published prior to 1990

### **Databases to be searched**

Academic Search Premier; Applied Social Sciences Index and Abstracts; Care Knowledge; CINAHL (EBSCO); MEDLINE (OVID); PsycINFO; ScienceDirect (Elsevier); SCOPUS; Sociological Abstracts (CSA); Social Care Online; Social Services Abstracts; Swetswise; Web of Knowledge (ISI); Wiley

### **Search for Grey Literature**

Centre for Mental Health; DART- Europe E-theses Portal; Department of Health; EthOS; General Social Care Council; Google Scholar; Intute: Social Sciences; Mental Health in Higher Education; MIND; Social Care Institute for Excellence; Social Perspectives Network; Social Policy and Social Work Policy Information Service; Social Services Research Group; Social Science Research Network; System for Information on Grey Literature in Europe Archive (SIGLE); Web of Science with Conference Proceedings (ISI)

### **Hand search of key journals**

British Journal of Social Work; Journal of Social Work; Qualitative Social Work

**Citation search of key articles**

The citations of key articles will be searched using the ancestry approach.

**Author search**

If an author is identified as writing key articles, then I will search for his/her other work, including work-in-progress, using the Web of Knowledge (ISI) database.

## Appendix Three: The search process

### DATABASE SEARCH

Database: Academic Search Premier; CINAHL; MEDLINE (13 May 2011)

1. sw\* AND mh\* AND interprofessional\* OR inter-professional\* OR inter professional\* in all fields  
Results: Academic Search Premier (387); CINAHL (338); MEDLINE (425) – search too wide.
2. sw\* AND mh\* AND interprofessional\* OR inter-professional\* OR inter professional\* in abstract – search too wide  
Results: Academic Search Premier (279); CINAHL (239); MEDLINE (303)
3. sw\* AND mh\* AND interprofessional\* OR inter-professional\* OR “inter professional\*” in subject terms  
Results: Academic Search Premier (4); CINAHL (36); MEDLINE (39)  
65 articles excluded on abstract – 6 articles excluded on full-text - 8 full-text retrieved
4. sw\* AND mh\* AND interagenc\* OR inter-agenc\* OR “inter agenc\*” in subject terms  
Results: Academic Search Premier (0); CINAHL (0); MEDLINE (0)
5. sw\* AND mh\* AND interdisciplinary\* OR inter-disciplinar\* OR “inter disciplinar\*” in subject terms  
Results: Academic Search Premier (4); CINAHL (7); MEDLINE (9)  
1 duplication 19 excluded on abstract – 0 full-text retrieved
6. sw\* AND mh\* AND multidisciplinary\* OR multi-disciplinar\* in subject terms  
Results: Academic Search Premier (642); CINAHL (14130); MEDLINE (0)  
AND identit\* added  
Results: Academic Search Premier (2); CINAHL (12); MEDLINE (0)  
12 excluded on abstract – 0 full-text retrieved
7. sw\* AND mh\* AND partnership\* in subject terms  
Results: Academic Search Premier (2); CINAHL (0); MEDLINE (1)  
3 excluded on abstract – 0 full-text retrieved
8. sw\* AND mh\* AND multi-professional\*\* in subject terms  
Results: Academic Search Premier (0); CINAHL (0); MEDLINE (0)
9. sw\* AND mh\* AND identit\* in subject terms  
Results: Academic Search Premier (3); CINAHL (8); MEDLINE (4)  
15 excluded on abstract – 1 full-text retrieved

Database: Applied Social Sciences Index and Abstracts; Social Service Abstracts; Sociological Abstracts

10. sw\* AND mh\* AND interprofessional\* OR inter-professional\* OR inter professional\* in KW (title, abstract; descriptors) (13 May 2011)



Results: Applied Social Sciences Index and Abstracts (13); Social Service Abstracts (21); Sociological Abstracts (5)

26 excluded; 3 duplicates – 0 full-text retrieved

11. sw\* AND mh\* AND interprofessional\* OR inter-professional\* OR inter professional\* in abstract (17 May 2011)  
Results: Applied Social Sciences Index and Abstracts (140); Social Service Abstracts (25); Sociological Abstracts (37)  
192 excluded – 10 full-text retrieved
12. sw\* AND mh\* AND interprofessional\* OR inter-professional\* OR “inter professional\*” in descriptors (13 May 2011)  
Results: Applied Social Sciences Index and Abstracts (0); Social Service Abstracts (9); Sociological Abstracts (1)  
8 excluded – 2 full-text retrieved
13. sw\* AND mh\* AND interagenc\* OR inter-agenc\* OR “inter agenc\*” in descriptors (17 May 2011)  
Results: 3 duplicates Applied Social Sciences Index and Abstracts (552); Social Service Abstracts (0); Sociological Abstracts (0)  
543 excluded – 6 full-text retrieved
14. sw\* AND mh\* AND interdisciplinary\* OR inter-disciplinar\* OR “inter disciplinar\*” in descriptors (17 May 2011)  
Results: 1 duplicate Applied Social Sciences Index and Abstracts (8); Social Service Abstracts (9); Sociological Abstracts (0)  
14 excluded – 3 full-text retrieved
15. sw\* AND mh\* AND multidisciplinary\* OR multi-disciplinar\* in descriptors (17 May 2011)  
Results: Applied Social Sciences Index and Abstracts (0); Social Service Abstracts (0); Sociological Abstracts (0)
16. sw\* AND mh\* AND partnership\* in descriptors (17 May 2011)  
Results: Applied Social Sciences Index and Abstracts (0); Social Service Abstracts (0); Sociological Abstracts (0)
17. sw\* AND mh\* AND multi-professional\* in descriptors (17 May 2011)  
Results: Applied Social Sciences Index and Abstracts (0); Social Service Abstracts (0); Sociological Abstracts (0)
18. sw\* AND mh\* AND identit\* in descriptors (13 May 2011)  
Results: Applied Social Sciences Index and Abstracts (1); Social Service Abstracts (7); Sociological Abstracts (0)  
5 excluded – 3 full-text retrieved

Database: Care knowledge (17 May 2011)

19. Social work AND mental health (keyword search)

Results: 32 records found; 31 excluded – 1 full-text retrieved

Database: Swetswise (17 May 2011)

20. Social work AND mental health (keyword search)  
Results: 18 results found; 14 excluded – 4 full-text retrieved
21. Social work AND mental health (title search)  
Results: 68 results found; 2 duplicates; 59 excluded – 7 full-text retrieved

Database: Scopus (20 May 2011)

22. sw\* AND mh\* AND interprofessional\* OR inter-professional\* OR inter professional\* in TITLE-ABS-KEY (title, abstract; key words)  
Results: 130 found; 120 excluded – 10 full-text retrieved
23. sw\* AND mh\* AND interagenc\* OR inter-agenc\* OR “inter agenc\*” in TITLE-ABS-KEY (title, abstract; key words)  
Results: 46 found; 46 excluded – 0 full-text retrieved
24. sw\* AND mh\* AND interdisciplinary\* OR inter-disciplinar\* OR “inter disciplinar\*” in TITLE-ABS-KEY (title, abstract; key words)  
Results: 118 found; 117 excluded – 1 full-text retrieved
25. sw\* AND mh\* AND multidisciplinar\* OR multi-disciplinar\* in TITLE-ABS-KEY (title, abstract; key words)  
Results: 161 found; 154 excluded – 7 full-text retrieved
26. sw\* AND mh\* AND partnership\* in TITLE-ABS-KEY (title, abstract; key words)  
Results: 94 found; 91 excluded – 3 full-text retrieved
27. sw\* AND mh\* AND multi-professional\* in TITLE-ABS-KEY (title, abstract; key words)  
Results: 8 found; 8 excluded – 0 full-text retrieved
28. sw\* AND mh\* AND identit\* in TITLE-ABS-KEY (title, abstract; key words)  
Results: 91 found; 86 excluded – 5 full-text retrieved

Database: Social care online (SCIE) (20 May 2011)

29. sw\* AND mh\* AND interprofessional\* OR inter-professional\* OR inter professional\* in free text  
Results: 71 found; 59 excluded – 12 full-text retrieved
30. sw\* AND mh\* AND interagenc\* OR inter-agenc\* OR “inter agenc\*” in free text  
Results: 65 found; 61 excluded – 4 full-text retrieved
31. sw\* AND mh\* AND interdisciplinary\* OR inter-disciplinar\* OR “inter disciplinar\*” in free text  
Results: 43 found; 43 excluded – 0 full-text retrieved
32. sw\* AND mh\* AND multidisciplinar\* OR multi-disciplinar\* in free text  
Results: 139 found; 134 excluded – 5 full-text retrieved
33. sw\* AND mh\* AND partnership\* in free text  
Results: 91 found; 87 excluded – 4 full-text retrieved
34. sw\* AND mh\* AND multi-professional\* in free text  
Results: 7 found; 7 excluded – 0 full-text retrieved

35. sw\* AND mh\* AND identit\* in free text  
Results: 127 found; 126 excluded – 1 full-text retrieved

Database: ScienceDirect (20 May 2011)

36. “social work\*” AND “mental health\*” in TITLE-ABS-KEY (title, abstract; key words)  
Results: 92 found; 91 excluded – 1 full-text retrieved

Database: ISI Web of Knowledge (20 May 2011)

37. sw\* AND mh\* AND interprofessional\* OR inter-professional\* OR inter professional\* in topic  
Results: 152 found; 152 excluded – 0 full-text retrieved
38. sw\* AND mh\* AND interagenc\* OR inter-agenc\* OR “inter agenc\*” in topic  
Results: 32 found; 32 excluded – 0 full-text retrieved
39. sw\* AND mh\* AND interdisciplinary\* OR inter-disciplinar\* OR “inter disciplinar\*” in topic  
Results: 80 found; 80 excluded – 0 full-text retrieved
40. sw\* AND mh\* AND multidisciplinar\* OR multi-disciplinar\* in topic  
Results: 123 found; 121 excluded – 2 full-text retrieved

#### GREY LITERATURE SEARCH

Source: Centre for Mental Health (15 June 2011)

41. sw and mental health  
Results: 67 found; 58 excluded – 9 full-text retrieved
42. sw and identity  
Results: 23 found; 4 duplicates; 18 excluded – 1 full-text retrieved

Source: EthOS (15 June 2011)

43. sw and mental health  
Results: 5 found; 1 duplicate; 3 excluded – 3 full-text retrieved, 1 excluded
44. sw and identity  
Results: 16 found; 5 duplicates; 6 excluded – 3 full-text retrieved, 1 excluded  
Plus 2 relevant but not available on-line

Source: Social Science Research Network (15 June 2011)

45. sw\* and mental health\*

Results: 215 found; 212 excluded – 3 full citations retrieved

46. sw\* and identity\*

Results: 215 found; 3 duplicates; 209 excluded – 3 full citations retrieved

Source: Social Services Research Group (22 June 2011)

47. sw\* and mh\*

Results: 22 found; 21 excluded – 1 full-text retrieved

48. sw\* and identity\*

Results: 6 found; 5 excluded – 1 full-text retrieved

Source: Dart- Europe E-theses portal (15 June 2011)

49. sw and mh

Results: 7 found; 4 duplicates; 3 excluded – 0 full-text retrieved

50. sw and identity

Results: 30 found; 3 duplicates; 17 excluded – 0 full-text retrieved

Source: System for Information on Grey Literature in Europe Archive (SIGLE) (15 June 2011)

51. sw and mh

Results: 40 found; 39 excluded – 1 full-text retrieved

52. sw and identity

Results: 4 found; 3 excluded – 1 full-text thesis viewed on-line and excluded

Source: Mental Health in Higher Education (mhhe) (15 June 2011)

53. Subject area: Social work in mental health

Results: 13 resources located

Source: General Social Care Council\_ (15 June 2011)

54. Mh

Results: 3 found; 2 excluded – 1 full-text retrieved

55. Identity

Results: 4 found; 4 excluded – 0 full-text retrieved

Source: Intute: Social Sciences (15 June 2011)

- 56. sw and mental health  
Results: 45 found; 38 excluded – 7 resources located
- 57. sw and identity  
Results: 9 found; 9 excluded – 0 full-text retrieved

Source: Social Perspectives Network (15 June 2011)

- 58. searched site for relevant papers  
Results: 23 found; 3 duplicates; 17 excluded – 3 full-text retrieved

Source: ISI Web of Knowledge with conference proceedings\_(15 June 2011)

- 59. sw and mh  
Results: 36 found; 34 excluded – 2 full citations retrieved; 2 excluded – 0 full-text retrieved
- 60. sw and identity  
Results: 15 found; 13 excluded – 2 full citations retrieved; 1 excluded – 1 full-text requested from author

Source: MIND (23 June 2011)

- 61. Sw  
Results: 317 found; 310 excluded; 7 full-text downloaded; 4 excluded – 3 full-text retrieved

Source: Department of Health (23 June 2011)

- 62. Mental health legislation  
Results: 3 found; 3 full-text retrieved
- 63. sw and mh and interagency or inter-agency or inter agency  
Results: 2 found; 2 excluded – 0 full-text retrieved
- 64. sw and mh and interprofessional or inter professional or inter-professional  
Results: 0 found – 0 full-text retrieved
- 65. sw and mh and interdisciplinary or inter disciplinary or inter-disciplinary  
Results: 0 found – 0 full-text retrieved
- 66. sw and mh and multidisciplinary or multi disciplinary or multi-disciplinary  
Results: 5 found; 5 excluded - 0 full-text retrieved
- 67. sw and mh and multi-professional  
Results: 1 found; 1 excluded - 0 full-text retrieved
- 68. sw and mh and partnership  
Results: 2 found; 2 excluded - 0 full-text retrieved
- 69. sw and mh and identity  
Results: 0 found - 0 full-text retrieved

70. mental health act 2007

Results: 31 found; 28 excluded - 3 full-text retrieved

Source: Mental Health Alliance (23 June 2011)

71. free search of website (no search facility)

Results: 4 found - 4 full-text retrieved

Source: BASW (23 June 2011)

72. free search of website (no search facility)

Results: 4 found - 4 full-text retrieved

Source: Google Scholar (23 June 2011)

73. sw and mh and identity

Results: 220 found; 111 excluded – 4 full-text articles retrieved and 5 books identified as relevant

Source: University of Salford Talisprism (11 July 2011)

74. sw and mh

Results: 255 found; 247 excluded – 8 books retrieved

## Appendix Four: Full text articles retrieved and excluded in the second stage

Full reference	Reason for Exclusion
Prior, P.M (1992) The Approved Social Worker – Reflections on Origins, <i>British Journal of Social Work</i> , 22, 105-119	Not empirical research
Huxley, P. and Kerfoot, M. (1994) A survey of Approved Social Work in England and Wales, <i>British Journal of Social Work</i> , 24, 311-324	Postal questionnaire only to senior managers of ASWs. Is only concerned with numbers and location of ASWs
Onyett, S., Heppleston, T. and Bushnell, D. (1994) The organisation and operation of community mental health teams in England and Wales. The Sainsbury Centre for Mental Health	Telephone and postal questionnaire only to senior managers of CMHTs. Is only concerned with the organisation and operation of CMHTs
Moss, R. (1994) Community mental health teams: a developing culture, <i>Journal of Mental Health</i> , 3, 2, 167-176	The article does not report original research.
Galvin, S.W. and McCarthy, S. (1994) Multi-disciplinary community teams: clinging to the wreckage, <i>Journal of Mental Health</i> , 3, 2, 157-167	The article does not report original research. It is a critical evaluation of CMHTs.
Onyett, S. and Ford, R. (1996) Multi-disciplinary community teams: where is the wreckage?, <i>Journal of Mental Health</i> , 5, 1, 47-55	Not empirical research. It is a critique of the article (above) by Galvin and McCarthy (1994).
Onyett, S. (1997) Collaboration and the community mental health team, <i>Journal of Interprofessional Care</i> , 11, 3 257-267	Not empirical research. General discussion of CMHTs
Thompson, P. (2004) Practice at the outer limits of approved social work, <i>Practice</i> , 9, 4 57-65	Not empirical research.
Hancock, M., Villeneuve, L. and Hill, R. (1997) Together We Stand – Effective Partnerships: Key indicators for joint working in mental health. The Sainsbury Centre for Mental Health. London	The report was concerned with developing key indicators and so was not directly relevant to my research question.
Horder, W. (1998) The care programme approach: interprofessional perspectives on mental health aftercare, <i>Practice</i> , 10, 2, 49-59	Although this is empirical research, the quality and the relevance to my thesis are weak. The social workers are not based in an interprofessional mental health team.
Peck, E. (1999) Emerging arrangements for the provision of mental health services, <i>The Mental Health Review</i> , 4, 3, 12-17	Not empirical research. It is a review of mental health policy.
Walton, P. (1999) Social work and mental health:	Not empirical research. However, it

Full reference	Reason for Exclusion
refocusing the training agenda for ASWs, <i>Social Work Education</i> , 18, 4. 375-388	does make some excellent theoretical points that will be relevant for my research.
Richards, G. and Horder, W. (1999) Mental health training: the process of collaboration, <i>Social Work Education</i> , 18, 4, 449-458	This was empirical research into a training programme. As such, it was not relevant to my research.
Ledwith, F. (1999) Policy contradictions and collaboration in community mental health services in Britain, <i>International Journal of Public Sector Management</i> , 12, 3. 236-248	This was a high quality paper but the focus was the organisational, managerial and structural impact of mental health policy. As such, it was not relevant to my research.
Norman, I.J. and Peck, E. (1999) Working together in adult community mental health services: an inter-professional dialogue, <i>Journal of Mental Health</i> , 8, 3, 217-230	The paper is not relevant to my research as no mention is made of the views of social workers.
Walton, P. (2000) Reforming the Mental Health Act 1983: an approved social worker perspective, <i>Journal of Social Welfare and Family Law</i> , 22, 4, 401-414	This was not empirical research. However the views expressed by the ASWs are pertinent to my thesis.
Peay, J. (2000) Reform of the Mental Health Act 1983: squandering an opportunity?, <i>Journal of Mental Health Law</i> , 8, 5-15	This is not empirical research but is a discussion of the Richardson Report (1999) and the Green Paper (1999) on the Reform on the Mental Health Act 1983.
Barnes, D., Carpenter, J. and Dickinson, C. (2000) Interprofessional education for community mental health: attitude to community care and professional stereotypes, <i>Social Work Education</i> , 19, 6, 565-583	This was an empirical study but not relevant to my research as it was about education.
Miller, C. and Ahmad, Y. (2000) Collaboration and partnership: an effective response to complexity and fragmentation or solution built on sand?, <i>International Journal of Sociology and Social Policy</i> , 20, 5/6, 1-38	This was not empirical research.
Lymbery, M. (2000) Evaluation: the lost dimension of community care, <i>Research Policy and Planning</i> , 18, 3, 1-25	This was not empirical research
McCulloch, A., Warner, L. and Villeneuve, L. (2000) taking your partners: using opportunities for inter-agency partnership in mental health. The Sainsbury Centre for Mental Health. London	This is not empirical research.
Cook, G., Gerrish, K. and Clarke, C. (2001) Decision-	The interprofessional team in this



Full reference	Reason for Exclusion
making in teams: issues arising from two UK evaluations, <i>Journal of Interprofessional Care</i> , 15, 2, 141-151	study only consisted of social workers, nurses and support workers. As such it was not a CMHT.
Thompson, N. (2001) Commentary: working together across disciplines, <i>Nursing Times Research</i> , 6, 837-838	This is not empirical research.
Grounds, A. (2001) Reforming the Mental Health Act, <i>British Journal of Psychiatry</i> , 179, 387-389	This is not empirical research. It is an analysis of the White Paper (2000) Reforming the MHA 1983.
Butler, I. and Drakeford, M. (2001) Which Blair Project? Communitarianism, social authoritarianism and social work, <i>Journal of Social Work</i> , 1, 7, 7-19	This is not empirical research. However, it is a key article.
Stanley, N. and Manthorpe, J. (2001) Reading mental health inquires: messages for social work, <i>Journal of Social Work</i> , 1, 1, 77-99	This is not empirical research. It is a systematic literature review of mental health inquires.
Bland, R. and Renouf, N. (2001) Social work and the mental health team, <i>Australasian Psychiatry</i> , 9, 3, 238-241	This is not empirical research.
Villeneuve, L., Hill, R., Hancock, M. and Wolf, J. (2001) Establishing process indicators for joint working in mental health: rationale and results from a national survey, <i>Journal of Interprofessional Care</i> , 15, 4, 329-340	The article summarises the research study already discussed in full above [Hancock, M., Villeneuve, L. and Hill, R. (1997)]
Shaw, A. and Shaw, I. (2001) Risk research in a risk society, <i>Research Policy and Planning</i> , 19, 1, 1-33	This is not empirical research
Marriott, S., Audini, B., Lelliott, P. Webb, Y. and Duffett, R. (2001) Research into the Mental Health Act: a qualitative study of the views of those using or affected by it, <i>Journal of Mental Health</i> , 10, 1, 33-39	The paper was concerned with the use of Mental Health Act but little was relevant to my research.
Huxley, P. (2001) The contribution of social science to mental health services research and development: a SWOT analysis, <i>Journal of Mental Health</i> , 10, 2, 117-120	This was not empirical research but an editorial outlining the strengths, weaknesses, opportunities and threats of the capacity for integration of social science into mental health services research.

Full reference	Reason for Exclusion
<p>Campbell, J., Wilson, G., Britton, F., Hamilton, B., Hughes, P. and Manktelow, R. (2001) The management and supervision of Approved Social Workers: aspects of law, policy and practice, <i>Journal of Social Welfare and Family Law</i>, 23, 2, 155-172</p>	<p>The paper reports on the first extensive survey of ASWs activity in Northern Ireland. It is an overview of the management supervision and practice of ASWs.</p>
<p>Hudson, B. (2002) Integrated care and structural change in England: the case of Care Trusts</p>	<p>The paper is not empirical research.</p>
<p>Herod, J., and Lymbery, M. (2002) The social work role in multi-disciplinary teams, <i>Practice</i>, 14, 4, 17-27</p>	<p>Although this is empirical research, it is not a mental health team but is a learning disability team.</p>
<p>Huxley, P. and Evans, S. (2003) Social science and mental health, <i>Journal of Mental Health</i>, 12, 6, 543-550</p>	<p>This is not empirical research.</p>
<p>Snell, J. (2003) Do you speak my language? <i>Community Care</i>, issue 1461, 28- 31</p>	<p>This is not empirical research. It is article discussing the progress of joint working between nurses and social workers in Great Britain.</p>
<p>Slay, G. (2003) What exactly is it that we do? <i>Professional Social Work</i>, December, 16-17</p>	<p>This is not empirical research.</p>
<p>Simpson, A., Miller, C. and Bowers, L. (2003) The history of the Care Programme Approach in England: where did it go wrong? <i>Journal of Mental Health</i>, 12, 5, 489-504</p>	<p>The paper does not report empirical research</p>
<p>Barter, K (2003) Social Work Identity and Purpose: real or imagined? In W. Shera (Editor) <i>Emerging Perspectives in Anti-oppressive Practice</i>. Canadian Scholars Press: Toronto</p>	<p>This is not a paper reporting empirical research. It is a book chapter. However, the subject of the chapter – social work identity – is highly relevant to my thesis.</p>
<p>Bronstein, L. (2003) A Model for Interdisciplinary Collaboration, <i>Social Work</i>, 48, 3, 297-306</p>	<p>This is not a paper reporting empirical research</p>
<p>Johnson, P., Wistow, G., Schulz, R. and Hardy, B. (2003) Interagency and interprofessional collaboration in community care: the interdependence of structures and values, <i>Journal of Interprofessional Care</i>, 17, 1, 69-83</p>	<p>This is not a paper reporting original empirical research. It is a review of the literature in the UK and USA.</p>
<p>Bowers, L., Clark, N. and Callaghan, P. (2004) Multidisciplinary reflections on assessment for</p>	<p>This is empirical research. However, it is concerned with the process of</p>

Full reference	Reason for Exclusion
compulsory admission: the views of Approved Social Workers, General Practitioners, ambulance crews, police, Community Psychiatric Nurses and Psychiatrists, British Journal of Social Work, 33, 961-968	assessment for compulsory admission rather than multi-disciplinary working per se: as such, it is not relevant to my research.
Fakhoury, W.K.H. and Wright, D. (2004) A national survey of Approved Social Workers in the UK: information, communication and training need, British Journal of Social Work, 34, 663-675	This is empirical research. However, it is concerned with the training, information and communication needs of ASWs and not social work identity or multi-disciplinary practice: as such, it is not relevant to my research.
Frost, N. and Robinson, M. (2004) Social work practice and identity in joined up teams: some findings from a research project, Social Work and Social Sciences Review, 11, 3, 16-28	This is empirical research. However, it is concerned with joined up teams in children's services which have a different mix of professionals so is not applicable.
Warner, L. (2005) Review of the literature on the Care Programme Approach. The Sainsbury Centre for Mental Health	This is not a paper reporting original empirical research. It is a review of the literature in the UK relating to the CPA.
Rapaport, J. (2005) Policy swings over thirty-five years of mental health social work in England and Wales 1969-2004, Practice, 17, 1, 43-56	This is not original empirical research.
Huxley, P., Evans, S., Webber, M. and Gately, C. (2005) Staff shortages in the mental health workforce: the case of the disappearing approved social worker, Health and Social Care in the Community, 13, 6, 504-513	The paper calculates the actual numbers of ASWs in the workforce. As such, it is not relevant to my research.
White, S. and Featherstone, B. (2005) Communicating misunderstandings: multi-agency work as social practice, Child and Family Social Work, 10, 207-216	Although it is not directly relevant to my research as it discusses interprofessional working in children's and family social work, it will be useful elsewhere in my thesis.
Ross, A. (2005) Professional identities, inter-professional relationships and collaborative working: an investigation using a constructivist phenomenological approach. A thesis submitted to the University of Huddersfield in partial fulfilment of the requirements for the degree of Doctor of Philosophy	It has been excluded as it is not concerned with mental health social workers of CMHTs.
Rapaport, J. (2005) New roles in mental health: the creation of the Approved Mental Health Practitioner, Journal of Integrated Care, 14, 5, 37-	The paper does not report original empirical research. It outlines the proposed change from ASW to AMPH

Full reference	Reason for Exclusion
46	drawing on literature and a conference discussing the proposed change.
Gould, N. (2005) An inclusive approach to knowledge for mental health social work practice, <i>British Journal of Social Work</i> , 36, 109-125	The paper does not report original empirical research.
NIMHE/CSIP (2005) The social work contribution to mental health services: a discussion paper	This paper does not report original empirical research
NIMHE/CSIP (2006) The social work contribution to mental health services: the future direction – report of responses to the discussion paper	This paper does not report original empirical research.
Freeman, T. and Peck, E. (2006) Evaluating partnerships: a case study of integrated specialist mental health services, <i>Health and Social Care in the Community</i> , 14, 5, 408-417	Although this is empirical research, it does not mention social workers and groups all staff members together
Richardson, S. and Asthana, S. (2006) Inter-agency information sharing in health and social care services: the role of professional culture, <i>British Journal of Social Work</i> , 36, 657-669	This is not a paper reporting original empirical research. It is a review of the literature in the UK relating to the inter-agency information sharing.
Campbell, J., Brophy, L., Healy, B. and O'Brien, A.M. (2006) International perspectives on the use of Community Treatment Orders: implications for mental health social workers, <i>British Journal of Social Work</i> , 36, 1101-1118	This paper does not report original research but compares the use of CTOs in Australia, Canada and the UK.
Payne, M, (2006) Identity politics in multi-professional teams: palliative care social work, <i>Journal of Social Work</i> , 6, 2, 137-150	This is not a paper reporting original empirical research.
Fawcett, B. (2007) Consistencies and inconsistencies: mental health, compulsory treatment and community capacity building in England, Wales and Australia, <i>British Journal of Social Work</i> , 37, 1027-1042	This is not a paper reporting original empirical research.
Pilgrim, D. (2007) New “mental health” legislation for England and Wales: some aspects of consensus and conflict, <i>Journal of Social Policy</i> , 36, 1, 79-95	This is not a paper reporting original empirical research. It explores the main points of dispute between the government and the Mental Health Alliance to the proposals to replace the Mental Health Act 1983.
Health Care Commission/ Commission for Social Care Inspection (2007) No voice, no choice: a joint review of adult community mental health services in England	This is a review of the experiences of people who use mental health services of community mental healthcare. It does not examine the work of social

Full reference	Reason for Exclusion
	workers.
Gould, N., Huxley, P. and Tew, J. (2007) Finding a direction for social research in mental health: establishing proprieties and developing capacity, <i>Journal of Social Work</i> , 7, 179-196	This is not a paper reporting original empirical research
Reynolds, J (2007) Discourses of inter-professionalism, <i>British Journal of Social Work</i> , 37, 441-457	This paper reports the findings of a study of discussions about interprofessionalism in an online forum for Open University social work students on a course in “managed care”.
Ray, M., Pugh, R. with Roberts, D. and Beech, B. (2008): Mental health and social work: research briefing. Social Care Institute for Excellence	This is a SCIE research briefing on mental health and social work.
Koussoulou, D. (2008) Changing roles and responsibilities, <i>Mental Health Today</i> , April, 28-30	This is not a paper reporting original empirical research. It outlines the key changes to the roles and responsibilities of mental health practitioners following the MHA 2007.
Prins, H. (2008) Counterblast: the Mental Health Act 2007 (A hard Act to follow), <i>The Howard Journal</i> , 47, 1, 81-85	This is not a paper reporting original empirical research. It is an article outlining the key changes made by the Mental Health Act 2007 to forensic mental health services.
Rapaport, J. and Manthorpe, J. (2008) Family matters: developments concerning the role of the Nearest Relative and social worker under mental health law in England and Wales, <i>British Journal of Social Work</i> , 38, 1115-1131	This is not a paper reporting original empirical research. It considers the changing role of relatives, carers and practitioners in the light of amendments by the MHA 2007.
Rapaport, J. and Manthorpe, J. (2008) Putting it into practice: will the new Mental Health Act slow down or accelerate integrated working?, <i>Journal of Integrated Care</i> , 16, 4, 22-29	This is not a paper reporting original empirical research. It outlines some of the changes introduced by the Mental Health Act 2007.
Collins, S. (2008) Statutory social workers: stress, job satisfaction, coping, social support and individual difference, <i>British Journal of Social Work</i> , 38, 1173-1193	The paper undertakes a review of the literature.
Huxley, P., Evans, S., Munroe, M. and Cestari, L. (2008) Integrating health and social care in community mental health teams in the UK: a study of assessments and eligibility criteria in England, <i>Health and Social Care in the Community</i> , 16, 5, 476-482	This is empirical research but the subject matter – Fair Access to Care eligibility criteria – is not relevant to my thesis.

Full reference	Reason for Exclusion
Hatfield, B. (2008) Powers to detain under mental Health legislation in England and the role of the Approved Social Worker: an analysis of patterns and trends under the 1983 Mental Health Act in six Local Authorities, <i>British Journal of Social Work</i> , 38, 1553-1571	This paper examines individuals assessed under the MHA over a 9 year period.
Hall, C. and Slembrouck, S. (2009) Professional categorization, risk management and inter-agency communication in public inquiries into disastrous outcomes, <i>British Journal of Social Work</i> , 39, 280-298	This paper discusses the concept of categorization illustrated through excerpts from two public inquiries.
Hunter, M. (2009) "We're sharing values now", <i>Community Care</i> , 18 June, 26-27	This article reports on the experiences of the first cohort of new AMHPs to complete their training.
Hugman, R. (2009) But is it social work? Some reflections on mistaken identities, <i>British Journal of Social Work</i> , 39, 1138-1153	This article does not report empirical research.
Wackerhausen, S. (2009) Collaboration, professional identity and reflection across boundaries, <i>Journal of Interprofessional Care</i> , 23, 5, 455-473	This article does not report empirical research.
Ramon, S. (2009) Adult mental health in a changing international context: the relevance to social work, <i>British Journal of Social Work</i> , 39, 1615-1622	This article does not report empirical research.
Sawyer, A. (2009) Mental health social workers negotiating risk on the frontline, <i>Australian Social Work</i> , 62, 4, 441-459	This paper reports original empirical research in Australia but is not relevant to my thesis as there is no discussion of social work identity and no mention of interprofessional working.
Furminger, E. and Webber, M. (2009) The effects of crisis resolution and home treatment on assessments under the 1983 Mental Health Act: an increased workload for Approved Social Workers?, <i>British Journal of Social Work</i> , 39, 901-917	This paper reports empirical research into the relationship between crisis resolution and home treatment teams and the use of the assessments under the MHA. It is not relevant to my thesis as there is no discussion of social work identity or interprofessional working.
McDonald, J. (2009) Beyond Professional Boundaries: the reflective practitioner, identity and emotional labour in social work. Thesis submitted in partial fulfilment of the requirement	This doctoral thesis explores reflective practice with individuals who contribute to social work education as students, academics, practice teachers

Full reference	Reason for Exclusion
for the award of Doctor of Social Sciences, University of Leicester	and practitioners and is not directly relevant to my thesis.
Nathan, J. and Webber, M. (2010) Mental health social work and the bureau-medicalisation of mental health care: identity in a changing world, <i>Journal of Social Work Practice</i> , 24, 1, 15-28	This paper is not reporting original empirical research.
Campbell, J. (2010) Deciding to detain: the use of compulsory mental health law by UK social workers, <i>British Journal of Social Work</i> , 40, 328-334	This paper is not reporting original empirical research.
Parker, J (2010) Approved Social Worker to Approved Mental Health Professional: evaluating the impact of changes within training and education, <i>Journal of Mental Health Training, Education and Practice</i> , 5, 2, 19-26	The paper reports an evaluation of the first year of AMHP training at Bournemouth University. It is concerned with issues such as selection and completion.
Bressington, D.T., Wells, H. and Graham, M. (2010) A concept mapping exploration of social workers' and mental health nurses' understanding of the role of the Approved mental Health Professional, <i>Nurse Education Today</i> , 31, 6, 564-570	This is a small scale (no=9) empirical study into a university AMHP interprofessional education programme but does not examine the participants' views of interprofessional working.
Cameron, A (2011) Impermeable boundaries? Developments in professional and inter-professional practice, <i>Journal of Interprofessional Care</i> , 25, 53-58	This is not a paper reporting an empirical study.

## Appendix five: Key to Jeffersonian transcription symbols

[ ] Overlapping speech: two brackets mark the beginning and end of overlap, one bracket marks the start.

↑↓ Marked pitch changes.

**Underlining** Emphasis on the underlined portion of talk.

**CAPITALS** Talk that is louder than surrounding speech.

°quiet° 'degree' signs mark quieter speech.

**(0.6)** Pause length in seconds and tenths of a second.

**(.)** A short pause, too short to measure.

**lo::ng** Colons represent elongation of the prior sound.

**hhh** Out-breaths.

**.hhh** In-breaths.

**Yeah,** Slight rise in intonation.

**Really?** Questioning intonation.

**Yes.** Falling intonation.

**bu-** a cut-off/unfinished word.

**>he said<** Speeded up talk.

**£definitely£** 'Smile' voice.

**heh ha** Voiced laughter.

**No wa(h)y** Laughter within speech.



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