Ethical Decision-Making in Child Protection Work by Health Visitors and Social Workers

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Thesis submitted in candidacy for the degree of

Doctor of Philosophy

The University of East Anglia

School of Social Work

May 2016

Abstract

This thesis is a qualitative enquiry of the role that interprofessional ethics plays in the decision-making between social workers and health visitors in child protection work. Through two in-depth discursive studies, the way that participants negotiate the complex ethical issues that run through practice is explored. The dynamics of interprofessional working and ways in which professionals construct identities within child protection work are examined. Focusing on language as a medium that both reflects and constructs social realities, the thesis provides an analysis of the professional positions that are adopted firstly in response to a case study and secondly within interviews. The first study, a preliminary investigation, considered the responses of five health visitors and nine social workers to an online case study. Building from this, the second study analysed talk within four semi-structured joint professional interviews with pairs of experienced professionals. The findings indicate that the fixed differences in perspective between the health visitors and the social workers within the study are minimal. As in previous studies, the influence of formal ethical frameworks is also difficult to detect, although there are some implicit frameworks for ethical decision-making that fit with those provided by moral philosophy. The contradictions and tensions within the professional accounts mirror tensions present within policy and guidance. The tendency for social workers and health visitors to emphasise their alignment during the interviews indicates that the performed identities of both groups might be more fluid and context sensitive than is often assumed within the literature about interprofessional practice. Instead professional identities are in flux, coalescing in relation to cases (at the individual level) and in relation to communities of practice (Wenger, 1998). The boundary work that delineates professional roles and identities can be seen as determined within less fixed and more situationally nuanced frameworks.

CONTENTS

Acknowledgements

Firstly, thank you to all of the practitioners who contributed to the research either as participants or as sounding boards for the ideas. More broadly I am thankful for all of the health visitors and social workers who strive to maintain high standards of ethical practice, often in the face of extreme challenges.

Secondly, I would like to thank my supervisors, Professor Neil Cooper and Professor Marian Brandon for their guidance, insight, encouragement and, not least, their patience. Thirdly my friends and colleagues at UEA and beyond whose kindness, wisdom and support I value greatly. In particular, I would like to thank Dr Laura Biggart without whom I would have struggled to have the self-belief required to even consider embarking on this project.

Last but not least I extend my love, appreciation and thanks to Emma and Tilly for all the love, humour and joy that they share with me.

INTRODUCTION

The Context of the Study

I became interested in both ethics in professional life, and Interprofessional working in my work as a social worker. From very early on in my career I was struck by the fragility of some professional relationships, the strength of others and the sometimes apparently unpredictable conflicts that arose within them. As I became more experienced, I developed a greater interest in the accounts that professionals offered about each other, and the extent to which ethical characteristics, or positions, were ascribed to other individuals or professional groups.

Unexpected conflicts between colleagues were common and I was provoked by this to try and answer a number of questions about the nature and meaning of the disagreements. In trying to make sense of them I began to notice that the conflicts had different characteristics. Some represented quite functional and helpful disagreements or perspectives on the needs of a family or a child. Others were overlaid with disappointment and/or anxiety about the outcomes of a child protection process. The origin and nature of some of these conflicts is covered well in the literature (Woodhouse and Pengelly, 1991, Henderson and Atkinson, 2003, Atkinson et al., 2007, Littlechild and Smith, 2013). Some authors suggest that conflicts are indicative of strategic or organisational disagreements (Percy-Smith, 2006). Others are more focused on the response to the deep rooted anxieties that occur amongst professionals engaged in child

protection work (Woodhouse and Pengelly, 1991, Cooper, 2005) and the concomitant projection of blame that unresolved anxieties might generate (Reder et al., 1993, Lees et al., 2011). Some authors have also looked at the way that professional roles and professional identities might cause conflicts and misunderstandings (Reder and Duncan, 2003, Bell and Allain, 2011) including status and stereotyping. Professional culture, and the impact that this may have on professional relationships, is also a recurrent theme (Hall, 2005, Richardson and Asthana, 2006) including the processes by which professional enculturalisation occurs (Dingwall, 1977b, Rose, 2011). Sometimes the effect of this is characterised as 'professional tribalism' (Hudson, 2002, Hood, 2015). The latter suggests a 'solid' view of professional identity that might form through training and education. In multi-professional contexts tribalistic conflicts might then emerge through either 'turf wars' – competition over professional spaces or decision-making – or through negotiating blame and responsibility.

The impact of the different value bases of professions is also a recurrent topic (Davies, 2003, Atkinson et al., 2007). Taylor and Thoburn (2016) make the point that professions tend to have broadly shared value bases, even if different disciplines use different language to express them. They argue that values should then be seen as an area of continuity between professions rather than as a barrier to working across them. Davies (2003) and Reynolds(2007) provide some limited evidence for this and posit a more 'fluid' version of professional identity where professional roles coalesce around a

common goal or activity rather than the more rooted sense of professional self-suggested in the tribalistic model.

Ethical Identities and Claims to Values

Values and ethics form an important part of the identity work that different professional bodies undertake (Beckett and Maynard, 2005, Banks, 2006b). Social workers and health visitors, alongside other professionals working in health and social care, might be expected to engage in 'identity work'(Taylor and White, 2000); that is working up of identities that posit desirable characteristics. These in turn link to the value claims for the profession that workers claim membership of. Professions might be seen to make claims to certain identities through statements about values. For example, social work's claim to support social justice positions the profession as an advocate for the disadvantaged, oppressed and marginalised.

Weinberg (2014) and Banks (2016) examine the idea of ethical identities in social work using interviews and case material respectively to explore some of the means by which identities are 'worked up' and accounted for within professional discourses. Weinberg in particular looks at the contradictions and 'ideological dilemmas' (Billig, 1987) - which she reframes as 'ethical dilemmas' – that occur within the accounts of a social worker reflecting upon their practice. Weinberg makes the point that these contradictions and tensions are derived from the discursive framework for the profession rather than solely located within the individual psychology of the worker themselves. At least part of that process, for Weinberg is the 'co-construction' of identity within dialogical

relationships with others (2014), with ethical identities an implicit part of this process.

Trust and the Professions

As noted by Banks (2008) the early twenty first century can be characterised as an era where ethics at both individual and institutional levels has become a key part of public debate. This has been mirrored by, and is in some ways reflective of, a concern about the character and conduct of professionals across a range of disciplines, including health and social care. O'Neill (2002) argues that the loss of trust in the discretion of powerful professionals is at the heart of this shift and suggests that new forms of accountability, largely in the form of what she characterises as 'audit accountability', designed to rekindle trust in the professions, may be ineffective in achieving this. Smith (2001) argues in a similar vein, suggesting that trust in professionals has been replaced by a wish for systems in which confidence might be placed. Banks (2004) extends this narrative, linking the shift towards managerialism - the focus on management skills rather than specific professional knowledge - to systems of accountability that might serve to individualise responsibility for error.

One response to these shifts in public trust and in the need to respond to the requirement for rigorous systems of accountability is the revision and reification of codes of ethics and codes of conduct.

Codes of Ethics and Codes of Conduct

At a formal level, the claim to values of individual professions are embodied in codes of practice and ethics associated with each profession. Congress (2010) points out the conflicts between individual principles within codes of ethics –for example the need to hold confidentiality and the need to protect the individual or the public (p.29). Congress also points to the variation in form of different codes and general congruity in their intent. She sets out a number of key principles that inhabit codes across territories (and professions):

- Respect for persons
- Self-determination
- Confidentiality
- Social justice
- Human rights
- Professional integrity
- Non-discrimination
- Cultural competence

(Congress 2010 p. 21-23)

The core values identified here can also be seen in codes of ethics for other professions (for example NMC, 2008, 2015 for nurses, midwives and health visitors; DFE, 2013 for teachers). Despite their different forms, codes across professions have tended to converge in recent years, supporting the point that Taylor and Thoburn (2016) make about continuity of values between professional groups. In both social work and nursing there have also been a number of revisions to codes within the last two decades. This has been in part

as a response to changing regulatory bodies, and in part a response to the shifting context of publicly delivered services. Some of these changes have come about as a result of changes in political leadership associated with the development of the economy (Parton, 2014). Some changes have occurred as a direct or indirect consequence of high-profile cases such as the death of Peter Connelly (in the case of social work) and the changes in the organisation and regulation of social work and social work education that followed. In health settings, the Francis report into the Mid-Staffordshire Hospital (NHS, 2013) had a significant impact on both public and political debates about nursing and the delivery of care within health settings.

Ethics and Values in Child Protection

There is a significant body of commentary on the ethical challenges of child protection work for professionals (Dingwall, et al., 1995, Peckover, 2002, Hugman, 2005b). The challenges identified by Dingwall et al include the positioning of social workers (and other professionals) in the space between the rights of parents/carers, children and the state. Peckover (2002) identifies the ethically uncomfortable position of health visitors sitting between the desire to support and align themselves with parents (often mothers in particular) but also negotiating the requirement to be vigilant on behalf of the child. This requirement to monitor and evaluate the wellbeing of children will sometimes involve health visitors in a more controlling role in relation to parents (Abbott and Wallace, 1998b).

Although the roles of health visitors and social workers are not symmetrical within the child protection arena, there are considerable overlaps in the context in which they operate (inside the family home) and in the tensions that emerge from their roles. Dickens (2013) suggests that these tensions are inherent to the role of social workers and that professionals are continuously drawn between competing responsibilities – to the state on one hand and to the individual on the other. Peckover (2002, 2011) makes slightly different but parallel arguments about the ambivalent position of health visitors in relation to parents.

Using Practice Experience

It was a sense of this tension and ambivalence, and the implications for ethical decision-making and interprofessional relationships, that I wished to focus on in this research. From both my practice experience and my reading of the literature, I could see that interprofessional conflicts could well emerge from different professionals collapsing into one or another ethical or value position in a particular case. In a situation where a child is removed from their parents, for example, the health visitor might align themselves with the rights of parents to care for their own children and for children to grow up with their birth family. They might do this whilst acknowledging that children also have a right to protection and the chance to meet their developmental potential. The social worker, by contrast, whilst acknowledging the rights of families to remain together, might invoke the child's right to safety and wellbeing as being of greater importance than the rights of parents to care for their children. In any given case the positions might easily be reversed, depending on a number of

contextual factors that might sway decision-making, not least the possibility that plausible and defensible arguments might be made for both courses of action in both cases.

Indeterminacy

The indeterminacy of outcomes makes decision-making of any kind within this area of work difficult. Professionals therefore have to operate under conditions of uncertainty, where technical and procedural knowledge are necessary but insufficient in making decisions about how to proceed (Howe, 2014). In her review of the child protection system in England, Munro (2011) draws attention to the limitations of a 'technical' approach and suggests that a turn to a 'socio-technical' understanding of decision-making in child protection might be a better framework for operating within this field and facilitate a more sensitive and robust system for making sense of errors when they occur. As Hood suggests:

> 'Instead of trying to perfect the managerial control of practice, the system aims to equip practitioners with sufficient resources and skills to manage complexity as they find it, i.e. on a case by-case basis.' (Hood, 2014, p. 2)

The reification of professional judgment that proceeded from Munro does, however, arguably leave the individual professional just as exposed to the anxieties that lie deep within child protection work (Bower, 2003; Woodhouse

and Pengelly, 1991). Within this uncertainty professionals are in effect required to employ a range of skills, knowledge and values in order to make sense of the work they do and to make defensible (if not always perfect) decisions about how to proceed (Keys, 2009). Gray, et al (2009) cited by Howe (2014) indicate that this mix of sources for decision-making requires the individual worker to take a reflexive and critical stance towards their work. This might include moving beyond foundational views of knowledge to include a more complex understanding of how knowledge itself is constructed within certain frameworks of understanding (Taylor and White, 2001). Within this context certainties about professional identity and a reliance on 'knowing what I know' (Anning, 2001) seem insufficient for a basis for making sense of interprofessional practice, and indeed for ethical decision-making.

Reflections from Practice

I worked in a children's centre where I was a local authority social worker. There was a multidisciplinary team, where some people were employed by the Sure Start project, and other people were placed there by their employing agencies. I was one of those, seconded into the project by the local authority. There was also a group of health professionals, including a psychologist, speech and language therapists, a midwife and a small team of health visitors.

What I already knew about working with health visitors was that it was possible to establish close working relationships with them, but I also found that conflicts would arise, sometimes unexpectedly. I was often surprised that someone I thought I was getting on very well with would get angry or cross

with me. One example of this was in a situation where I was trying to come to a decision about how to manage a case. In this instance there was a young parent with three young children and there were lots of professional concerns about neglect. There were ongoing questions about whether the care was ‘good enough’, and whether the children were suffering significant harm. When I was discussing this with the health visitor, I was quite open about my uncertainty about what the right thing to do was and that I was trying to work this out with her. The health visitor suddenly became quite defensive and suggested that I was trying to get her to make all the decisions for me.

Another example was where my manager directed me to close a case where I assessed that a family met the threshold for our service, but my manager disagreed and overruled me. The health visitor subsequently became angry that I was ceasing my involvement and asked me why I couldn’t just ignore my manager and do what I thought was right. I could see that conflicts tended to emerge over difficult cases and my interest was drawn to the language that was used by professionals in these instances. Social workers sometimes talked about health visitors being small-minded, manipulative, or acting in bad faith. It struck me that much of this language had moral connotations. Health visitors would use similar language and would describe social workers as being punitive. For example, where decisions were made to remove children from the care of their parents, social workers were described as punishing them. Conversely, social workers would often be said to be punishing or neglecting children and siding with parents when they were left in the family home against the judgement of the health visitor.

It struck me that there was an ethical or moral judgement being made through the ways in which health visitors and social workers were criticising each other. They wanted to present themselves as ethically just in the positions that they were taking. I wondered whether there was an element of professional misunderstanding in what was going on. This came, in part, from my role in the project as being translational - explaining social work views to health visitors and vice versa. I wondered whether this grew from genuine professional differences in considering what was right and wrong; or from different professional practices; or whether there might be some similarity in their positions and whether they might be interchangeable. It seemed to me that the professionals' views could often have been swapped around quite easily.

In order to look at this in more depth, I considered two approaches that might be useful. Firstly, I wanted to explore whether social workers and health visitors saw themselves as holding different values. Secondly, I wanted to talk to social workers and health visitors in pairs to explore what they thought about how they worked together. My first thought was to talk to pairs who got on well together as it seemed to me that we already knew a lot about professionals falling out with each other in child protection, but less about how they got on well together. When I read Working Together (HM Government, 2015) it struck me that beyond general exhortations to work with each other, there was little guidance or ideas about how to do this successfully. I was interested in how these professionals worked this out as they went along.

Research Questions

The questions were prompted by the practice experience that I have referred to above, and by my first-hand experience of inter professional conflicts. My sense was that many of the professional differences that were foregrounded by workers emerge from the difficult nature of the work itself, rather than any intrinsic value differences between professions. The research questions were intended to interrogate this idea further.

The Research Questions were:

- How do health visitors and social workers talk about the ethical dimensions of their work?

- How do they approach ethical conflicts in joint working?

- Are there differences in the ethical priorities of the two groups?

Outline of the thesis

The literature review is set out in three chapters. The first considers the history of both health visiting and social work in the UK, and in particular the debates

about values and ethics that have developed over time. It also considers the current position of ethical frameworks within both professions and the role of professional codes of conduct and ethics in framing practice.

The second chapter looks at the literature on interprofessional practice and the ways that debates about public trust in professional groups have challenged the identities within those groups. It also contains a discussion about the development of policy and guidance on interprofessional working through an analysis of the Working Together documents. The third chapter focuses on the application of discursive methodologies within health and social care settings, including some research which considers how practitioners operate within ethical frameworks.

The methodology chapter lays out the rationale for the approach taken to the research and describes the data collection processes and the ethical issues that arose during the fieldwork element of the PhD. In this chapter I will discuss the reasons for adopting an approach that focuses on accounts given by health visitors and social workers, rather than other approaches that might have been taken to examining this area. The main analytical approach is drawn from discursive psychology. Discourse theory is concerned with both the constitutive and referential aspects of language (Wetherell et al., 2001). It assumes a social constructionist view of the world, and primarily approaches language as a representation of culturally produced account of the world rather than a representation of an individual's inner self (Potter and Wetherell, 1987). The interviews were approached with this method of analysis in mind.

There are three analysis chapters. The first is a summary of the findings from a case study that health visitors and social workers responded to online. This chapter presents some descriptive data and the analysis of free text data from the participants. The two subsequent chapters comprise the main findings from the analysis of interviews with pairs of social workers and health visitors.

The final chapter is a discussion of the findings as a whole and some implications for practice in joint or interprofessional working in child protection. This chapter also considers the contribution that this study makes to our understanding of ethical practice and ethical decision-making in child protection work.

Chapter 1

Ethics and Values in Social Work and Health visiting

Introduction

Both social work and health visiting in the United Kingdom have historical roots in the development of health and social welfare services during the intense industrialization of the Nineteenth Century (Billingham et al., 1996, Gregory and Holloway, 2005). From their inception, both professions identified themselves as 'moral enterprises' (Banks, 2006b). Although their functions and organization have changed considerably over time, both retain a strong 'claim to values' as part of their professional identity (Bisman, 2004). This chapter will consider some of the different approaches to ethics that are present within the literature relating to the professions. I will start by looking briefly at the historical development of values and ethics in both professional groups. The chapter will them explore different ethical frameworks in health and social care. Finally, I will consider some current issues within the ethics literature, and how these might relate to different constructions of professional identity for both social work and health visiting that have emerged in recent years.

Historical roots

1.1 The development of social work

Holloway and Gregory (2005) attempt to provide an historical frame within which to understand the development of social work identity and the social work task. Writing from a social constructionist perspective, they suggest that the language used to describe social work is active in constructing the

profession itself. They suggest that there have been three distinct phases of social work in the UK, each characterized by a dominant discourse. In its earliest manifestations, social work had a clear moral function. Social work itself arose as a profession as a consequence of the social problems generated by the development of industrial capitalism (Abbott and Wallace, 1998). The 'moral enterprise' of social work at that time was an attempt either to reform or bring back in to society those who had 'fallen' either through poverty or vice (Gregory and Holloway, 2005). Gregory and Holloway suggest that rather than acting as agents of social justice, social workers at that time would have identified individual rather than structural failings as the cause of 'social evils'. As the 'therapeutic enterprise' in the post-Second World War period, the orientation of social work changed to a clinical one, within a 'diagnose and treat' model of practice (Gregory and Holloway, 2005). Working within a social context of 'ontological security' (Giddens, 1991), social workers sought to understand and adjust the individual to society. In the 'managerial enterprise' social work is presented as a profession dominated by risk management and consumerist expectations of its services. The authors date this phase as one that emerged in the 1990s and which continues to dominate the organization and practice of social work (Gregory and Holloway, 2005). They point to the shifts in language in policy documents and in practice that reflect and enact these new priorities: 'There are 'corporate plans', 'business strategies' and 'key performance indicators' (Gregory and Holloway, 2005 p.47). They also point to the shift in formal descriptive language within probation, with the shift in terminology from 'client' to 'offender' to describe those who are subject to its services.

Stevenson (1998) also attempts to track the development of social work practice through the post-war years. Focusing on the changes in child welfare practice, Stevenson cites the problematic absence of 'an indigenous coherent body of practice theory for social work' (Stevenson, 1998, p.156) as a major brake on the development of confidence in the social work profession in the UK. In terms of the values of social work, she identifies the shift away from 'rescuing' and 'fresh start' models of intervention with children towards keeping and reuniting children with their birth families. This, Stevenson suggests, was a reaction, in both policy and practice, to the removal of children from their families on a large scale that had occurred earlier in the century.

1.2 Health Visiting

Health visiting also emerged in the philanthropic movements of the 19th Century (Billingham et al., 1996). Like social work, the early model of practice lay in home visiting to the poor and needy. With health visiting though, the concern was with physical rather than moral hygiene (Billingham et al., 1996). During the course of the century practice shifted from a public environmental health role to engagement with prevention and work with whole families (Smith, 1996). A more direct role in maternity and paediatric welfare emerged during the early part of the 20th Century. Smith (1996) suggests that by the time of the development of the welfare state in the 1940s, health visiting was in direct competition with social work. She describes the 'encroachment of social work on its traditional sphere of child welfare' in one direction (p.44). In

the area of primary health care, the establishment of a national health service and the availability of doctors to families for no fee, meant a lowering of demand for health visiting (Smith, 1996). The reorganization of local authorities in 1974 led to the transfer of responsibilities for health visiting from local authorities to new health authorities (Billingham et al., 1996).

Currently health visiting is commissioned through Local Authorities in England and Wales (DoH, 2015). The route to professional training as a health visitor is through nursing, and the distinction between the two professions in terms of their knowledge and values base has been increasingly blurred (Smith, 1996, Robinson, 1998). The Nursing and Midwifery Council (NMC) govern the professional regulation of health visiting for example, and the two professions share a code of conduct (NMC, 2015).

Abbott and Wallace (1998) suggest that health visiting in its earliest forms involved the exercise of 'pastoral power' (Abbott and Wallace, 1998a). They position health visitors in a surveillance role in relation to the family and as agents of social control. They see health visiting as an 'individualistic mode of intervention' mandated by medical discourses relating to the well-being of children. They suggest a shift in focus from child survival in the early part of the 20th century to child development in the current period as a consequence of the falling rates of infant mortality. Although this role has shifted they still see health visitors as an intrusive and controlling force:

> ‘Health visitors played a role in creating and identifying the ‘inadequate mother’. They then became involved in programmes of reform to transform her, to shape her behaviour so that she becomes an adequate, a good enough mother’ (Abbott and Wallace, 1998a,p.22).

Although this description is somewhat at odds with Smith’s depiction of a profession that stands up for the collective rights of women and children, and offers advice and befriending at an individual level (1996); it bears comparison with the sociological depiction of social work in the same chapter (Abbott and Wallace, 1998a). Other writers have also highlighted the potential for control and coercion within the health visiting role (Peckover, 2002;Twinn, 1991 Naish, 1995). The tension between care and coercion and conflicts within the central values of both social work and health visiting are important themes.

1.3 The development of professional ethics

These changes in the role and definition of social work are reflected to some degree in the development of the ethical and value base of the profession. Reamer (1998), writing from a United States perspective, identifies four historical stages of social work ethics. He suggests that there has been a noticeable shift from a preoccupation with the moral fitness of service users in social work’s early constructions, towards a more ‘mature’ consideration of the ethical and moral complexities of practice itself (Reamer, 1998). The four stages – the morality period, the values period, the ethical and decision-making period and the ethical standards and risk management period – mirror

the shifts in professional identity that Gregory and Holloway suggest. Reamer states that a ‘critical mass’ of literature emerged at the end of the 1950s in what he calls the ‘values period’. However, he suggests that ethical theory in social work only began to emerge in the 1980s with the development of applied and professional ethics. Reamer cites the application of ideas from moral philosophy as key to this development. Additionally, he proposes that development of the social work literature in this area parallels increased public concern about the misappropriation of professional power (Reamer, 1998). During this period, he contends, social work lined up with other professions in developing an ethics literature of its own. At the fourth and contemporary stage of development, he suggests that there has been ’maturation’ in the understanding of ethical issues within the social work profession. Banks refers to the ‘ethics boom’ (Banks, 2008) to describe the same expansion in interest in and concern about ethics in health and social care professions in general. However, Banks takes a more critical view than Reamer of where the drivers for this development have come from, and what the consequences for practice might be. Reamer links the increase in the literature with a greater awareness of accountability and a greater understanding of the ethical complexity of practice (Reamer, 2006). Banks takes a more measured and sceptical view, particularly in relation to the evolution of codes of practice and codes of ethics and the translation of formal ethical understanding into practice. Banks suggests a movement beyond codes of ethics is required and proposes a movement towards a ‘situated social work ethics’ (Banks, 2008,p.1242) based upon a sensitivity to ethics in practice. She comments on the relative absence

of ‘descriptive ethics’ based upon empirical research into the way that practitioners make ethical judgments in everyday practice.

Writing in the early twenty-first century, Barnard (2008) suggests four ‘spheres’ of values within social work. They derive from moral philosophy, the law, political ideology and the fourth from the emergence of social work as a profession the struggle for a professional identity that has engaged social workers (Barnard et al., 2008). This close association between values and ethics and the identity of social work as a profession is frequently reiterated within the literature (Banks, 2006b; Hugman, 2005b; Beckett and Maynard, 2005; Reamer, 1998). The claim to distinct values - such as a commitment to social justice - are often presented as a support for social work’s distinctiveness as a profession. As with Gregory and Holloway, Barnard expresses concern that the normative values that have marked the traditions of social work – such as compassion, being non-judgmental and a commitment to social justice – have been reduced to an amoral and value neutral stance (Barnard et al., 2008). The rules and prescriptions of ‘new managerialsim’ are seen as a direct threat to the value traditions of social work in a ‘risk society’ (Webb, 2006). Banks (2004) identifies a threat to professional identity and professional values in the increasing prescriptions and erosion of professional judgment in social care professions. Banks uses the phrase ‘New accountability’ (Banks, 2004) to identify a trend towards distrust of the professions, and consequent attempt to control and direct professional practice to a high degree.

1.4 Codes of ethics and codes of conduct

Social workers registered with the Health and Care Professions Council (HCPC) are required to abide by a number of standards. The two principle standards are those which relate to proficiency (HCPC 2012) and the Standards of conduct, performance and ethics. Other codes frequently referred to within the literature are generated by the British Association of Social Workers (BASW), which is an independent professional body, and the International Federation of Social Workers (IFSW). Banks (2012) notes the principle-based nature of codes (p.85) with a strong emphasis on deontological principles, placing obligations on individuals to act in accordance with them. Congress (2010) suggests that codes represent the key values of a profession and provide a framework for enacting those values in practice. In doing so they embody a number of normative values, for example social justice, non-discrimination and respect for persons. Bisman argues that these values have a dual function in that they represent the beliefs of a profession but also help to construct its identity (Bisman, 2004). However there is mixed evidence from research that codes of ethics are well known to practitioners, and little research to indicate how well they are used in day-to-day practice (Congress, 2010; McAuliffe, 2005).

Nurses in the UK are governed by a code of ethics and conduct that is combined by the Nursing and Midwifery Council (NMC). The most recent version was issued in 2015 and is entitled ‘The Code’ (NMC, 2015). Pattison and Wainwright (2010) point to a number of recent revisions to the Code of Ethics for nursing in the past 30 years (Pattison and Wainwright, 2010). In a

critique of one revision (NMC, 2008), they suggest that combinations of ethics, conduct and performance within a single document are problematic. Their main objection is what they see as a simplistic set of injunctions at the heart of the code, which they say function as a narrow set of prescriptions that do not encourage moral or ethical engagement with nursing practice. Furthermore, they suggest that the code restricts moral and ethical growth:

> '… the code may in some ways be confused regarding its ethical stance, and unrealistic and absolutist in a way that prevents nurses from learning and becoming more ethically aware, competent, responsive and responsible'
> (Pattison and Wainwright, 2010; p.15).

Webster (2010), in writing about the now defunct General Social Care Council, makes a similar point about codes of conduct for social workers in the UK. The HCPC, the regulator of social work at the time of writing, requires all social workers to be registered and to abide by the Code (HCPC, 2016). Failure to uphold the code of practice can result in sanctions against workers including dismissal (McLaughlin, 2010a). Webster (2010) emphasizes the role of the codes as a source of surveillance and control. He contrasts its disciplining function with codes of ethics that operate as beacons of illumination that might act as a guide to ethical practice (p.33). In common with Pattison and Wainwright, Webster argues that codes may be insufficient to promote moral agency and may limit the engagement of the individual in moral and ethical decision-making (Webster, 2010;Dawson, 1994). McLaughlin

extends the critique to include concerns about surveillance extending beyond professional practice to the personal lives of social workers and questions the legitimacy of disciplining individuals for activities that are outside their professional role (2010).

Banks suggests that professional codes offer a reminder to professionals that they have ethical responsibilities that lie beyond the restrictive interpretations of their role that their agency may lay out for them (Banks, 2006b). They might also provide a resource for action to redress injustice or to defend professional identity. Banks also acknowledges the role that codes of ethics and codes of conduct might play in disciplining and controlling the autonomy of powerful professionals such as social workers.

1.5 Ethical decision-making

Some contemporary writers challenge the limitations of ‘check list’ approaches to ethical decision-making for practitioners (Banks, 2009b). There has also been a renewed interest in approaches which value the qualities and characteristics of the practitioner as well as their technical knowledge and skills required to undertake their role (Clark, 2006, Adams, 2009). Challenges to traditional approaches have also emerged from feminist and postmodern perspectives, both of which challenge ideas of justice and universality present within Kantian and consequentialist accounts (Lloyd, 2010).

In a critique of current approaches to professional ethics within education and training, Banks (2009) suggests that textbooks and documents are overly

concerned with codes of practice and decision-making models (p.56). She suggests that a ‘traditional’ approach can be characterized by three main features; Codes of Ethics, Conduct and Cases. Banks provides a detailed commentary on these three features suggesting that they contribute to a simplistic and abstracted approach to ethical thinking for both students and professionals. Her objections to the three features can be summarized as follows:

1. Codes of Ethics are seen as potentially problematic for two reasons. Firstly, they are ‘externally generated’ (p.56), rules imposed from professional, or regulating bodies. The significance of this is linked to Banks’ second point, which is the tendency for the whole of ethics to be associated with ‘conformity to rules and standards’. In other words, all professionals within a given group, for example social workers, are required to conform to a set of requirements not generated by their own moral perception or reasoning. In this context, Banks is suggesting, ethics become a checklist of obligations.
2. Conduct becomes the focus of attention within these models. This is limiting, according to Banks, because it reduces ethical judgments to questioning whether particular courses of action were right or wrong according to ‘impartial general ethical principles’ (p.56).
3. Cases are presented (within the literature) which are abstracted from the situated reality of work with service users. Shorn of complexity, Banks argues, these case studies are often reduced to decision-making exercises ‘choices between two equally unwelcome alternatives’ (P.56).

The danger pointed out by Banks is that these approaches may have a reductive effect on perceptions of ethics, and are not sufficient, in themselves preparation for the moral demands placed on practitioners in practice. The alternative she suggests is to reframe professional ethics as ‘ethics in professional life’ (Banks 2009), thereby attempting to reposition the notion of ethical practice from a static, closed activity that has associations with deductive reasoning, to an open and dynamic engagement with moral complexity. Banks emphasizes the situated nature of ethical decisions, with a parallel critique of the use of case studies (as above) within teaching in health and social care, as well as within the literature.

Banks develops her argument further by referencing the tendency for teaching and textbooks to foreground the ‘difficult case’ for consideration by students. The difficulty with this approach, she argues, is that it promotes the idea that ethical judgments are only present within self-evidently contentious scenarios, for example where choices have to be made by practitioners about placing the rights and needs of one individual over another. She suggests that an alternative approach is required that encourages students and practitioners to be ‘seeing ethics everywhere’ (Banks 2009, p.61).

This account of the contemporary challenges and opportunities for developing ethical practice in professional life lines up the movement away from strictly rational approaches to ethical decision-making, with a wider rejection of rationalist only approaches to practice in the wider context. Banks makes this

opposition explicit in the final paragraph of this article, where she also positions her proposed approach to ‘ethics in professional life’ in opposition to ‘managerialist trends’ (p.62). Banks incorporates within this proposed approach an imperative to include ‘virtues, relationships and emotions’ (P.62), reflecting what she identifies as developing debates about ethics within philosophical thought.

1.6 Professional responsibility.

One area of concern within work with children and families is the extent and nature of personal responsibility held by professionals. Within the social work frame Hollis and Howe (1987) argue that the extent of personal responsibility is set when the individual makes the choice to become a social worker. Using the notion of ‘moral risk’, they argue that moral responsibility for poor outcomes in social work with children rests with the individual worker who makes the decisions. They suggest that when social workers make ‘risky’ decisions within their work, they take on a moral responsibility for the outcomes as well, and state that to accept the role is to accept personal responsibility for its exercise and hence for the moral risk inherent in difficult decisions (Hollis and Howe, 1990).

Crucially, they argue that moral responsibility is personally held, even where there is no issue of competence or failure to follow procedure. They use the analogy of an ambulance driver responding to an emergency call, who knowingly drives a mechanically faulty vehicle:

> ‘He cannot ignore the injured but if he crashes on the way to the hospital and kills his patients his moral responsibility for their deaths has to be judged not simply on his intention to save lives but also on the fatal outcome which was the result of his decision to drive a dangerous vehicle.’ (Hollis and Howe, 1990; p.550).

Hollis and Howe argue that in settings where there is a high degree of indeterminacy about the outcome of a decision, and where that decision involves some prior knowledge of a likelihood of a bad outcome; then judgments about the morality of the decision shift from the quality of the decision-making itself to the outcome of the decision. Thus, in terms of child protection, if a child is placed at home with parents where there is a known risk of harm, if the child is harmed or dies the moral responsibility lies with the social worker. This, according to Hollis and Howe, applies even where rules and procedures are followed.

Critics of this view (Macdonald, 1990, Banks, 2006a) argue that the allocation of blame to the individual social worker is misdirected for a number of reasons. Firstly, both Macdonald and Banks suggest that the distributed nature of decision-making within social care makes the apportioning of individual responsibility misleading. In practice, the decision-making process is shared amongst many people, so, they argue, moral responsibility for outcomes must be similarly distributed. Banks (2006) goes on to suggest that in taking singular responsibility for the outcome social workers are allowing

themselves to be ‘scapegoated’ One negative consequence of this may be a failure to correct technical or organizational failures in the wake of serious cases if an over emphasis is placed on individual responsibility, a point made by Banks and others (Reder et al., 1993, Brandon et al., 2005)

Macdonald (1990a) challenges the idea that the moral rightness of decisions can be determined by their outcomes. She also takes issue with some other assumptions underlying Hollis and Howe’s argument. The desirability of individual moral responsibility being allocated to or claimed by social workers is a key issue here. Howe and Hollis (1987) cite this as an essential quality for safe and effective practice in social work. In drawing a distinction between moral and legal responsibility, they suggest that the former is an inevitable and desirable aspect of social work. They suggest that moral tensions exist within the role, originating from competing responsibilities to justice and welfare as well as the risks associated with removing children form their parent’s care, are an essential aspect of the work. For them identifying the relationship between the personal and the professional ethic is a requirement of the professional role. The implication of this is a collapse of the distinction between the private and the professional in order to be effective:

> ‘In effect a circle of ‘special duties’ intervenes between the narrow circle of a private and personal morality and the wider circle of universal moral duties laid on every citizen or human being. All too often these circles refuse to line up so neatly so as to give a single compass bearing. When this happens, the

> professional doctor or social worker cannot simply live in compartments, playing the role in office hours and behaving quite differently outside it.'
> (Hollis and Howe, 1990, p.552).

If Hollis and Howe's claim is accepted, there are significant implications for social workers and other health and social care professionals and how they identify the limits of their role and their moral liability.

Macdonald (1990b) suggests that a focus on the evidence of what works in child protection is a more useful and desirable way of delivering 'good' outcomes. She emphasizes the importance of knowledge and skills, alongside values and ethics, but draws a clearer distinction between intention and outcome. For Macdonald, moral integrity is maintained by 'doing the right thing' for the right reasons, regardless of outcome. Moral engagement is bounded by the professional role, which, by implication, does not require the same degree of moral commitment Hollis and Howe suggest. In common with McLaughlin's argument about the limits of on professional obligations permeating private lives (McLaughlin, 2010b) Macdonald argues for a limit on professional liability.

1.7 Ethics of care

Care ethics represent one of the approaches to the moral decision-making in health and social care that have become more prominent in recent decades

(Koggel and Orme, 2010). Its association with feminism is strong, although it is important to note that feminism is heterogeneous and care ethics represent one contested strand of feminist ethics (Hugman, 2005b). This approach to ethics emerged with the writings of Carol Gilligan, 'In a different Voice' (Gilligan, 1982), which was an attempt to account for apparent differences in the moral development and perceptions of men and women.

Carol Gilligan's starting point was a challenge to the negative representation of the moral development of women that emerges from the work of Kohlberg (1981). Kohlberg's work on identifying the stages of moral development suggested that women tended not to achieve the higher levels associate with universal principles of justice (Kohlberg, 1981). Gilligan challenged Kohlberg on two premises. The first was the absence of women from many of his studies, which challenged his claim to universality (Gilligan, 1982). The second was that Kohlberg's work ignored what Gilligan saw as an alternative moral and ethical position, that of the ethic of care (Gilligan, 1982).The ethic of care is represented by Gilligan as comprising a different, and oppositional set of qualities to the duty based approach that underpinned Kohlberg's research. Where Kohlberg's stages of moral development trace a movement towards universal principles of justice, Gilligan posits a mode of moral thinking based on mutuality and interdependence (Koggel and Orme, 2010). Relationships, rather than abstract principles, become the basis for moral decision-making within this frame. Gilligan's account is firstly a rejection of the idea that the moral development of women is 'less than' that of men, and secondly a valorisation of a different approach to ethical thinking (Hekman, 1995).

In analysing Kohlberg's findings, Gilligan compares the rating given to responses by male participants to questions about morality with those given by female participants (1982: 19 – 21). She identifies different constructions of the moral problems presented to the participants within their responses. In this example, the differences fall along gender lines, with the female participant placing the ideas of interdependence and mutuality above rights and justice (1982:20). The male participant places most importance on 'recognizing the right of the individual' and acting towards others 'as fairly as you would have them treat you' (Kohlberg, 1981). According to Gilligan, in Kohlberg's rating system, the female participant's response would achieve a lower stage of moral development than the male participants would. Gilligan argues that the two responses demonstrate an equal degree of moral maturity, and the difference in the responses are representative of different, but both valid, ways of viewing moral responsibility:

> 'Within this construction, the moral dilemma changes from how to exercise one's rights without interfering with the rights of others, to how to lead a moral life which includes obligations to myself and my family and to people in general'.'
> (Gilligan, 1982,p.20)

At this stage of her work, Gilligan provides an account of gendered views of moral development in terms of life cycle development, and in particular the psychoanalytic interpretation of the distinct developmental trajectories of girls

and boys (Gilligan, 1982). Although in later work she acknowledges that in subsequent research both justice and care principles are invoked by both genders (Gilligan and Wiggins, 1988) Gilligan continued to challenge these findings on the basis that what is claimed in research may be quite different to what is found in everyday behaviour (p.113). In her view ‘two stories about morality recur in human experience’ (1988), and these two stories are directly linked to the psychosocial development of boys and girls. In concise terms, Gilligan suggests that boys need to separate from their primary care giver - usually their mother - in order to achieve a male adult identity. It is this process that leads to a preference for justice based moral decision-making (Gilligan, 1982) as autonomy, objectivity and fairness are. Girls on the other hand, do not need to separate in order to achieve a sense of female identity. Consequently, they self-define through a sense of connection and association with the primary care giver. In Gilligan’s formulation care ethics build on the sense of relationship and interdependence that emerges from the struggle to build a sense of identity based on the need to define the self in relation to, rather than in opposition to, the ‘other’.

1.8 Care Ethics in Social Work

The emphasis on relationships and mutuality that ethics of care promote would appear to be highly compatible with social work values. Although first posited in the discipline of psychology, the development of the literature about care ethics has taken place within a range of social sciences (Koggel and

Orme, 2010, Hekman, 1995). Within the social work literature, the debate appears to be more limited (Orme, 2002). There are two main challenges to the value base in social work that may partly account for this apparent reticence, both rooted in Gilligan's original formulation. The first is the essentialist position that Gilligan seems to adopt in her writings. Hekman (1995) identifies an ambiguity about whether care ethics derive from a biological and psychosocial 'fact' of women's lives or not. However other writers have both detected and reacted against this position (Featherstone, 2010). From a feminist perspective the valorisation of care, and its identification with womanhood, is as much a potential trap as it is a way of liberating the moral voice of women (Hollway, 2006). A second area of contention is Gilligan's view of the antithetical relationship between justice/deontological ethics and the ethics of care:

> 'Two moral injunctions – not to treat others unfairly and not to turn away from others in need – define two lines of moral development, providing different standards for assessing moral judgments and moral behaviour and pointing to changes in the understanding of what fairness means and what constitutes care.'
> (Gilligan and Wiggins, 1988, p.113).

This polarization of care and justice ethics is problematic for social work. Respect for the autonomy of the individual is a paramount principle in social work's codes of ethics and codes of conduct (BASW, GSCC). Rights and

justice discourses are a powerful warrant for social work interventions and could be said to be an expression of the most important and distinctive characteristics of the social work profession. Similarly, the concept of care is a key part of the social work self-concept. The 'parallax view' that Gilligan invokes, where either ethic can be seen individually but neither can be seen together, threatens a fractured and less than coherent view of social work values.

Two authors writing about social work theory and practice have attempted to bring the two approaches together. Held (2006) proposes that justice and care approaches can be seen as complimentary to each other, rejecting a model of ethical decision-making that requires the universal adoption of one ethic or the other. She argues that rather than being exclusive, the two approaches could be seen to have different, but complimentary priorities (Held, 2006). Held argues that neither frame offers a sufficient account either at a theoretical or an applied level. Held also argues against integration however, with the concomitant danger of the usefulness of the two different perspectives being lost:

> 'Too much integration will lose sight of these valid differences. I am more inclined to say that an adequate, comprehensive moral theory will have to include the insights of both the ethics of care and the ethics of justice, among other insights…'
>
> (Held, 2006, p.17).

Held approaches the problem of how and when to apply the different approaches in practice by separating their application into separate 'domains in which they should have priority' (2006, p.17). She uses the example of the law (justice and rights but care not forgotten) and family and friendships (care ethics) to delineate the different areas of priority. However, the difference in priority does not imply exclusion for Held. Instead, the dominance of one approach (law) suggests a starting point for a decision-making and the other (care) must be held in mind if a comprehensive moral response is to be achieved.

An example of the latter is the case of domestic violence. Held recapitulates earlier feminist responses to the limitations of an ethic of care to adequately respond to domestic violence. The compulsive, selfless care shown by many victims of domestic violence towards the perpetrator is part of the psychological mechanism that often traps them in the relationship (Radford and Hester, 2006). Failure to invoke the rights of victims in this context leads to more suffering for those individuals and their children. An ethics of care that requires the needs of both parties to be addressed risks leaving the gross power imbalance between them intact, failing to protect those most in need. A rights only basis for intervention can be equally unsatisfactory however, as the measures taken to intervene can themselves be disempowering to victims, as well as economically ruinous, and often too little to resolve the causes of violence in the short or long term (Held, 2010). Held argues that it is only by applying both ethical systems that we can begin to find satisfactory solutions.

One example of this is the recognition of the need of men who commit acts of domestic violence to address the underlying causes of their behaviour. The uses of the law to signal social support for the upholding of the victim's rights, and to sanction the perpetrator, then works alongside the imperative of care to investigate the needs of both parties in more depth.

Orme (2002) argues for the compatibility of care and justice approaches from a different perspective. Following Benhabib (1992) Orme describes a reworking of justice ethics that incorporates an imperative to care. Benhabib's critique of the Rawlsian model of justice rests in part on a challenge to the idea of the 'universal other' that allows for a rational determination of fairness from behind the 'veil of ignorance' (Benhabib, 1992). Benhabib argues that we can never be unencumbered by knowledge of our location within the social world, and that knowledge of our own gender, ethnicity, age and other characteristics inevitably informs our view of what is and might be fair. Consequently, in making judgments about fairness we have to refer to a concrete 'other', one that has a sense of their location within the social world that mirrors – but is not identical to – our own (1992, p.167). In this formulation care and justice become inimitable as establishing fairness involves knowing the concrete other in order to establish what their understanding of their own needs are. A 'communicative model of ethics subverts the distinction between an ethics of justice and rights and one of care and responsibility' (Benhabib, 1992,p.167).

From this analysis, Orme suggests a dialogical approach to social work practice that requires the service user to be 'someone to whom the

professional listens' (Orme, 2002). In doing so, Orme notes the compatibility of this approach with traditional social work values. However, she also offers a synthesised care and justice approach as a challenge to current practice, with a commitment to care and dialogue opening the door to a more complex understanding of the needs of those receiving care.

1.10 Virtue Ethics

Virtue ethics have become more prominent in the literature in health and social care since the beginning of the twentieth century. Originating in the classical world and associated with the work of the philosopher Aristotle, virtue ethics are derived from the idea of character rather than outcomes or principles.

As Beckett and Maynard (2013) suggest, character-based ethics have an intuitive appeal for those drawn to caring professions as they seem to sum up why we place our trust in some individuals rather than others. We define someone as 'good' primarily because of a set of characteristics that we sense in them for example because they are 'brave, loyal, generous and kind' (p. 31).

Howe (2014) points to the neat parallels between the qualities that service user's value in social workers and the precepts of virtue ethics:

> 'Clients tell us that they value warmth and friendliness, understanding and acceptance, reliability and a willingness

to listen, open-mindedness and ‘being straight’…’ (p.161).

Banks and Gallagher (2008) explore the potential for virtue ethics, alongside other approaches to ethical practice, in the broader context of health and social care. They suggest that considerations of character are appropriate for caring professions, even if virtues don’t completely answer the complexity of modern practice in any profession. In updating and applying virtues to the modern context the authors list - and apply through case studies - virtues that might be most salient to current practice: professional wisdom (phronesis); care; respectfulness; trustworthiness; justice; courage. In many respects these qualities map easily on to the requirements of character required by codes of practice and ethics. However, Banks and Gallagher make the point that for Aristotle the idea of virtues is inextricably linked to ‘eudaimonia’ or the good, or flourishing life (p. 43). Clark (2006) also makes use of the wider connotations of virtue ethics in extending the idea of character in social workers as an injunction to service users to live a ‘good life’. Harking back, to some extent, to the moral dispositions of social work in its earlier history, he suggests that workers need to move beyond assistance as a morally neutral activity into a morally purposeful one, orientated towards the idea that there are ‘good’ and ‘bad’ ways of living. He suggests that social workers should both model and proselytise these ways of being. Along with helping service users to achieve the material means to live the good life, social workers have an obligation to encourage the virtues in their clients.

McBeath and Webb (2002) explore the ethical autonomy that virtues seem to offer social work. Instead of preoccupations with outcomes and duties, they suggest, workers should engage with the situated moral complexity of their work and rely upon virtuous judgment rather than prescription or consequence in their decision-making. In presenting virtue ethics in this way, they align it as a moral framework in opposition to technical approaches to social work. Carr (1999) in a different context makes an analogous point to McBeath and Webb in arguing that if professionals are required to make judgements, they are by definition responding to moral rather than technical demands.

1.12 Summary

The histories of both social work and health visiting contain a struggle for professional recognition and status. Both professions have also made a claim to values as at least part of their claim to legitimacy and autonomy. Both have also had to adapt to changing cultural, economic and political environments and have developed their identity and role in reference to these historical shifts.

The development of professional ethics can be seen as part of the development of a professional identity for social work and for health visiting. Within the social work literature there has been a steady criticism of the limitations of deontological and consequentialist approaches to ethics (McBeath and Webb, 2002; Clark, 2006). At the same time there has also been a call to pay attention to approaches to ethics based on character (Adams, 2009), relationships (Houston, 2003; Orme, 2002) and in which

situational factors are considered (Banks, 2009b). Similar debates in nursing have led to discussions about the limitations of the standard principalist approaches to biomedical ethics. Similar discussions exist within the literature about the value of virtue and care-based approaches to ethics.

It is striking that the movement away from rule and outcome-based approaches to ethics have occurred at a time when professions appear more controlled and constrained by codes and managerial approaches than they have perhaps been historically. The debates about how these professions might frame their ethical identities may be a response to procedural orthodoxy as much as it is an attempt to grapple with cultural pluralism and a postmodern society (Hugman, 2003; Healy, 2007). The limited amount of research into how health and social care professionals make ethical decisions in practice makes it difficult to comment on the extent to which these shifts are present in everyday work. The extent to which professionals, including health visitors and social workers, can be seen as both autonomous in judgements and bound by regulation and technical guidance creates tensions in the sense of responsibility and agency that they can claim, or be subject to in their work. Weinberg (2014) explores this in her account of a worker caught up in the ‘ideological/ethical’ dilemma of either failing to ‘go the extra mile’ (supererogation) or meeting a commitment to self-care (p. 84). The rational challenge of moral luck, and to some extent care ethics, is the extent to which professionals can be enmeshed in responsibilities that they have not chosen, and outcomes that they cannot necessarily determine or control.

The next chapter looks at the general context of interprofessional working in child protection and makes use of the Working Together guidance as a metonymic representation of the ways in which policy shifts might illuminate some of dilemmas that professionals face within practice.

Chapter 2

Working Together in and Interprofessional practice in child protection work

Introduction

The literature on interprofessional working and safeguarding children tends to focus on two related themes. The first is the impact of poor or under-developed working relationships, often in relation to child deaths or serious injury (Brandon et al., 2009; Brandon et al 2005; Reder and Duncan, 2004; Laming, 2009). The second theme is concerned with the challenges and opportunities of working together (Frost and Robinson, 2007; White and Featherstone, 2005; Anning, 2001). Although these two themes are interrelated, I believe that it is useful to separate them within the discussion that follows within this chapter. The first theme will be considered in relation to the development of child welfare policy in the period following 1945 until 2015. The second part of the chapter will look at the attempts to enact these policy directives within organizations associated with child welfare and will look at the literature on interprofessional working.

Discussions in the literature about collaborative practice can be broadly understood as falling into three domains. The macro domain consists of the legal and policy framework and encompasses initiatives such as the Working Together documents, and on a larger scale the New Labour Every Child Matters initiative. At the intermediate level the literature examines the way that agencies and individual teams engage with each other for example Atkinson

et al., 2006 and Percy-Smith. A third area concerns itself with the micro level and comprises discussions about how individuals work together. One example of this would be Watkin et al., 2009 who look workers making decisions together in an interprofessional learning environment.

In the macro domain there is a recurring theme of collaboration requiring clear boundaries and direction. Some of the impetus for this comes from Inquiries into child deaths for instance following the Maria Colwell Enquiry (as mentioned earlier) the first memorandum on inter-agency and interprofessional collaboration was published by the government. Subsequently both the Laming Enquiry 2003 and the Munro Review 2011 highlighted issues of cooperation and communication as key to preventing further child deaths.

At the intermediate level there is a recognition within the literature that organisational frameworks and work climate play a specific role in the success of collaborative relationships. In Atkinson et al ‘s (2006) meta study, for example, whilst clear guidance and strong policy are seen as necessary, they are not seen as sufficient to ensure good practice. Their study does give some examples of work place cultures that may either promote or discourage good practice. Woodhouse and Pengelly (1991) theorise about the psychosocial processes that might influence individual and group behaviour in the context of child protection work. They emphasise the role that professional self-image might have in managing the inherent anxiety contained within child protection work.

Within the literature, there seems to be less attention paid to the micro level than the other two domains. This is one of the gaps that I am hoping my research question can fill, particularly within the ethical dimension of collaboration. Woodhouse and Pengelly (1991) get close to this in their examination of the collaborative triangle (p191). Their analysis shifts towards establishing worker responses within psycho-analytic archetypes rather than uncovering emerging categories. Murphy et al., (2006) look at the dynamics within a multi-agency youth offending team through use of interview material. They examine the attitudes towards professional identity and working together. They highlight some of the ways in which professional identities can be either thrown into relief or blurred into multi-professionalism. An example of this is the tension between welfare (social workers) and public protection (police officers) inherent within the work. Where these elements became salient, for instance, when a young person breached an order, they tended to generate these types of polarised subject positions within the team.

2.1 The Policy Context

Fox-Harding (Fox-Harding, 1997) identifies four dominant discourses in child welfare policy in the United Kingdom: laissez- faire, state paternalism, the defence of the birth family and children's rights. Fox-Harding sets the four discourses within historical shifts in the view of the relationship between the state and the family. Within this context, she includes changes in the macro structures of the state, such as those brought about by the health and social care reforms in the 1940s. Harding also identifies shifts in the perception of

both the family and of childhood itself that have been influenced by social movements such as feminism, and the children's rights movements (Smith, 2010). Fox-Harding suggests that these competing discourses are present within the legislative and policy developments in the post-war years. For example she draws attention to the tensions within the Children Act 1989 in England and Wales between the rights of children and anxiety about the power of the state to intervene in family life (Fox-Harding, 1997). In Fox-Harding's view, the values that underpin policy are not necessarily in concordance with each other, and the resultant legislation and guidance is likely to reflect contradictory views of children and family life. These competing policy discourses, as well as shifts in the meaning and value of children (Cunningham, 2006, James and Prout, 1997) create the ideological backdrop for professionals attempting to work together in child welfare.

2.2 Changing landscape of child protection

The first formal guidance for agencies collaborating in child welfare was issued in 1974 in the form of a DHSS circular (DHSS, 1974a). This guidance was issued following an enquiry into the death of Maria Colwell in 1973. Maria Colwell died from physical abuse whilst in the care of her mother and stepfather when she was seven years of age (Reder et al., 1993). The Colwell Report (DHSS, 1974b) had raised concerns that Maria had died despite the involvement of a number of agencies – including Social Services, Health, Education, Police, and the NSPCC. The issuing of the guidance coincided with the reorganization of local government in England and Wales and the

setting up of generic Social Services departments (Murphy, 1995). Murphy suggests that the coincidence of these two events placed considerable focus on both the newly formed departments, and the issue of multi-disciplinary working. He identifies three significant themes from the Colwell Report: communication, responsibility and systems (Murphy, 1995). These three issues are recurrent both in the literature about child abuse and in subsequent inquiries into child maltreatment (Reder and Duncan, 2004;Laming, 2009; Parton, 2004; Munro, 1999).

Murphy highlights the focus within the report on the responsibility of society – through the medium of agencies and their systems – rather than individual practitioners for the errors that led to Maria Colwell's death: 'Because that system is the product of society it is upon society as a whole that the ultimate blame must rest' (DHSS. 1974, p.86). The implications of a collective responsibility or failure – better working within and between all agencies - were realized within the subsequent guidance which emphasized better systems and closer inter-disciplinary working (Murphy, 1995). The failure of two central professionals who worked with Maria Colwell - an NSPCC officer and a local authority social worker - to communicate effectively with each other was identified as a key issue within the case. Murphy suggests that in this and later inquiries – such as the Cleveland enquiry (Butler-Sloss 1988) that tensions between professionals contributed to a lack of trust and an unwillingness to communicate. At least some of this tension is attributed to a struggle for 'control' between professional groups (Murphy 1995, p 13). In Cleveland, the lack of professional trust operated at an organizational as well

as an individual level, with communication between some agencies breaking down significantly (Campbell, 1988, Murphy, 1995).

Frost and Parton (2009) plot the development of guidance from the 1980s up to 2009. They note that from the setting up of Area Child Protection Committees in 1988 - designed to coordinate and improve multi-agency responses to child welfare - the guidance becomes more elaborate and more procedural. The 1991 document (Home Office et al, 1991) was published as a companion to the Children Act 1989 and established a set of principles for the interpretation of the Act. Frost and Parton suggest that the main focus at this stage was on establishing the concept of significant harm and that the central thrust of the guidance was on how professionals should respond to child protection issues (Frost and Parton, 2009). Horwath and Calder (1998) took issue with what they saw as a lack of prescription and procedure in relation to child protection processes at this time. Paying particular attention to the post-registration process (the work that is undertaken with families after a child's name has been placed on the child protection register), they lament the lack of clear structure and purpose around this work within local authorities. They specifically highlight the role confusion between different professionals within the child protection process. They suggest that one cause of this was the increased emphasis on partnership with parents that emerged in the Children Act 1989. Howarth and Calder claim this diluted the original focus on inter-agency working and placed an unhelpful burden upon the system (Horwath and Calder, 1998). They propose that this should be resolved through a

combination of recommendations about joint working based on research and clearer mandatory government guidance.

Frost and Parton suggest a gradually emerging formalization of practice that has developed from the 1970s to the 2000s (Frost and Parton, 2009). Within this they identify two key trends. Firstly, they point to the increasing prescription and elaboration of guidance in relation to child protection over this period. This they attribute in part to the impact of high-profile inquiries into child deaths, and a concomitant emphasis on the curbing of individual professional discretion. The second trend is the increased formalization of multi-agency working in child welfare services as a whole. They suggest that the formal frameworks around child protection were extended to cover all work undertaken with children and families (Frost and Parton, 2009).

Ferguson (2011) identifies the death of Maria Colwell as marking the time when child abuse became ‘visible’ again after several decades of being ‘unseen’ by the public. He argues that the ‘moral panic’ (Parton 1986) about child abuse that grew over the following decades was at least in part a product of the disappearance of child abuse from the public agenda since the death of Dennis O’Neil on 1945. Prior to the late 1940s, child deaths in the UK were more common (Ferguson, 2004). Ferguson estimates that before the reforms in health, education and state welfare during the immediate post-war period, that child deaths were fairly frequent occurrences (Ferguson, 2011). He suggests that the current comparative rarity of child deaths, combined with a change in the meaning of childhood itself led to a change in public knowledge

about child abuse. He argues that by the 1930s ‘children had gained a new sentimental value; while they were now economically ‘useless’, they were emotionally ‘priceless’ (Ferguson, 2011, p.27). Public sensitivity to child abuse combined with desire to protect the reputation of child protection services, led to a suppression of information about child deaths and serious injuries (Ferguson, 2011).

2.3 Working Together Guidance

Below is a tabulated account of the progressive Working Together documents alongside some of the general public and policy issues that coincided with, and in some cases directly informed, their publication.

Table 1. Illustrative portrayal of the progressive Working Together documents alongside wider public and policy context.

Working Together Published 1988	Followed 1986-draft guidance. Included responses to Cleveland and guidance on sexual abuse (Butler Sloss report published at the same time)	Public inquiries including Jasmine Beckford (1985) Kimberley Carlisle and Tyra Henry (1987)	Introduction of the National Curriculum	
Working Together Under the Children Act 1989 Published 1991	Following the Children Act 1989 United Nations Convention on the Rights of the Child (ratified 1991)		NHS and Community Care Act,1990	

Working Together to Safeguard Children Published 1999	Messages from Research (1995). Framework for Assessment published at same time (draft 1999)		Draft Care Standards Act (2000)	Setting up of the GSCC (2003) Change of registering body for the HVs to NMC (2002)
Working Together to Safeguard Children 2006	Response to Laming Report, 2003, ECM 2003/4, Children Act 2004			Options for Excellence in social work 2006, CWDC
Working Together to Safeguard Children 2010	Death of Peter Connelly and second Laming report.	Significant expansion in content	Social Work Reform Board, Social Work Task Force The College of Social Work	
Working Together to Safeguard Children 2013	Munro Report 2011. Call for a return to professional Judgment	Change of Government 2010	Francis Report into Mid Staffs. scandal	
Working Together to safeguard Children 2015		New Government 2015	Abolition of the College of Social Work	

2.4 Working Together 1988

Parton (2011) draws attention to the increased 'length and complexity' of the Working Together guidance since the first inter-agency memorandum was introduced in 1974. 1988 (Department of Health and Social Security, 1988) saw the first substantial piece of guidance - itself a revised edition of a consultation document issued two years before (DHSS, 1986). The introduction to the document presents it as a framework for the different

organisations involved in child protection to develop their own policies for cooperation and joint working:

‘It is essentially concerned with how agencies can develop agreed joint policies and the arrangements necessary for making them effective’ (DHSS, 1988; p. 5).

In the same spirit of non-prescription the document continues:

‘It does not attempt to provide guidelines on the practice of individual professions in the recognition of child abuse or subsequent care or treatment but is concerned with interprofessional and inter-agency co-operation’ (DHSS, 1988; p.5).

There is a broad emphasis within the document on the manner in which organisations should seek to work together, but this is balanced by some detailed guidance on how professionals should manage individual cases. Roughly half of the main body of the document concerns itself with work in individual case (including the section on child sexual abuse) and this is organised into two chapters (DHSS, 1988; Part 5&6). The guidance in these chapters seems quite detailed, and some could be construed as prescriptive. For example, the need to investigate all referrals (page 21) and the need to involve social workers as well as medical practitioners in investigations of abuse (page 22), along with the importance of sharing information (page 20) all present as imperatives rather than options for practitioners.

2.5 Cleveland Enquiry

Some of these imperatives relate directly to the impact of the Cleveland Enquiry (Secretary of State 1988), which was published at the same time as the guidance. The Enquiry report written by Butler-Sloss drew strong conclusions about inter-agency working and individual practice in relation to allegations of sexual abuse, Working Together (1988) represents the first inter-agency guidance on responding to sexual abuse. The enquiry followed the removal of large numbers of children from their families due to concerns about sexual abuse. A central concern within the report was the need for professionals from different agencies to cooperate more closely and to share decision-making in cases of abuse. One of the features of the Cleveland case was the breakdown in relationship between health practitioners, social workers and the police (Campbell, 1989). Some of the more specific guidance echoes the concerns raised in the Enquiry report:

‘The investigation of child abuse or risk of abuse always requires social as well as medical assessment’
(DHSS 1988; p.22).

And further on in the same section:
‘Medical evidence which may be inconclusive when seen in isolation may help to provide a clear picture of abuse when seen in conjunction with other evidence’
(DHSS 1988; p.22)

These comments relate directly to the concerns made in the report about the medical diagnosis failing to take into account social indicators, with the hospital doctors involved effectively making unilateral decisions both about whether children had been sexually abused and what should be done about it (Secretary of State 1988). This concern about the dominance of one professional perspective over another, and the need to balance power between professionals is mirrored in a concern about the need to attend the power differential between professionals and families. Parton (2011) suggests that this guidance, and its successor in 1991, is:

‘primarily concerned to ensure that professionals maintained a balance in their work between protecting children from abuse and protecting the privacy of the family from unnecessary and unwarranted intrusion’
(DHSS, 1991; p.7).

The guidance makes some specific reference to this in the section on the involvement of children and parents (p.29 -31) citing concerns from the European Court of Human Rights about the transparency and purpose of child protection investigations. These tensions between state power and family privacy and between the autonomy and the requirement for concordant assessment and action for different professional groups, is a recurrent theme throughout the development of the guidance.

2.6 Health Visitors and Social Workers in Working Together 1988

Despite the general title of the document, much of the more prescriptive guidance is directed at local authority social workers. Sometimes their identity is clearly labelled but for the most part the title of social worker is subsumed under several different roles. For example, within the section describing the processes required for inter-agency case conferences. There is a clear statement that the role of key worker should be undertaken by a social worker either from the local authority or the NSPCC (para 5.19). The paragraphs that follow this refer to the 'key worker' rather than the 'social worker' even though the impossibility of this role being held by another kind of worker is clear. Throughout the document the title social worker is subsumed by other names - 'professional' and 'practitioner' are common. Sometimes these labels are used to refer to number of possible kinds of worker, but at other times it is clear that the likely or only meaning is 'social worker'.

Specific reference to the social work role occurs in two other places. Part 6 of the document is given over to sexual abuse cases. This part of the guidance is explicitly informed by the Cleveland enquiry, and includes a quote from Butler-Sloss that includes the statement that 'The child is a person and not an object of concern' (DHSS, 1988, p.34). In the same paragraph (6.5) there is a warning to social workers and other professionals that they 'should not subject the child to unnecessary repeated interviewing' (p.34) underscoring the concern that 'the gathering of evidence of abuse should not become and additional source of abuse of the child' (p.34).

Paragraphs 3.2 and 3.3 (p.12-13) comment specifically on the roles of health visitors and midwives in child protection. The first paragraph emphasizes the importance of health visitors working closely with each other and the value of promoting and supporting good parenting. The latter is presented as preventative work as: ‘Child abuse is less likely if there is an affectionate and positive relationship between parents and baby’ (DHSS, 1988, p.12). This focus on prevention stands out in contrast to the largely reactive guidance throughout the rest of the document. It is also more redolent of, in policy terms, the more developmental model of safeguarding present within the later iterations of Working Together and of the Children Act 2004.

The second paragraph relating to health visiting is more reflective of the residual model of child welfare cast throughout the rest of the document. The section is titled ‘Monitoring a child’s development’ and uses the phrase ‘health surveillance’ to describe the role of health visitors and school nurses in detecting harm that may already have happened to children. There is also a reference to ‘domiciliary visits’ when children have not been in attendance at clinics. The language positions the health visitor as a vigilant overseer of family practices. This is more explicitly indicated in the words ‘monitoring’ and ‘surveillance’, and more implicitly in the mention of home visits ‘especially in cases where the child has not been brought to clinic’. The implication here is that the absence of children from clinics should raise particular concerns, and that the appropriate response to attempts to hide children from the gaze of medical professionals should be to investigate more thoroughly.

The presentation of the health-visiting role of befriender in the first paragraph contrasts with the investigative role implied in the second. Both roles are linked through a concern with the welfare of the child, but the means of achieving this is posited differently within the two accounts. The emphasis on relationships in the first paragraph is striking. Encouragement, and a good relationship with the parents, is required for supporting, in turn, good relationships between the parent and their child. In the second paragraph professional expertise (in child development) is brought to bear by the health visitor to identify deficient or abusive parenting. Although the two stances are not antithetical, there is a potential for tension between the role of befriender and the policing of families implied within Working Together. There are also pointers to tension within the professional identity of health visitors. Peckover (Peckover, 2002) points to the gendered assumptions about health visitors becoming ‘mother’s friend’, drawing upon skills that are attributed as much to being female as they are to any professional expertise. On the other hand the ‘hard’ knowledge of child development that comes from health visiting and nursing training is used to make judgments about the adequacy or otherwise of parenting (Peckover, 2002, Abbott and Wallace, 1998b).

2.7 Sharing Information and Collaboration

Despite the apparently straightforward title, there is very little detail about how workers from different professional groups should work together in practice.

Instead there are instructions and suggestions about how to build joint protocols and where joint working might be indicated. There are also suggestions about the importance of joint training (p.42-43) the value of specialist advice and the use of expertise (p.31, and p. 35-36) and the need for joint specialist teams to respond to sexual abuse in particular (p.36). The latter follows from a recommendation by Butler-Sloss and seems to be a direct response to the apparent breakdown of working arrangements between the police, social worker and medical staff in the Cleveland case.

There is some general guidance on the sharing of 'relevant' information (p.19) particularly with social services and the police. This section of the document refers back to professional guidance that relates specifically to doctors and to nurses midwives and health visitors (para. 54. and 5.5, p.19 and 20).

2.8 Working Together 1991

The 1991 guidance is entitled 'Working Together Under the Children Act 1989' (HMSO, 1991) and was published following the 1989 Act coming into law. The guidance was published in A4 format – as opposed to A5 for the 1988 document - and the main guidance runs to 60 pages (from 39 in 1988 - Parton claims more, but he has not excluded the copyright and blank pages at the front which are numbered in the document).

Some aspects of the guidance follow the format of its predecessor, but the ordering of information and visual presentation are different. For example, the document is arranged into eight rather than nine parts and the guidance for

the running of Area Child protection Committees is moved to Part 2 towards the front of the document. Parton (2011) points out that although the guidance follows the Children Act 1989, it selects out any reference to preventative or supportive services under Section 17 of the Act. Instead there is an emphasis on identifying and responding to significant harm.

The guidance does reflect the balance between state intervention and the preservation of family life present within the Act itself. In the introduction (Part 1, p.1) the first banner statement concerns the 'Need to Work in Partnership with Families'. In Part 5.11 (p.27) there is a more explicit statement:

'The balance needs to be struck between taking action designed to protect the child from abuse whilst at the same time protecting him or her and the family from the harm caused by unnecessary intervention' (HMSO, 1991, p.27).

This statement chimes with Parton's observation about the previous guidance (Parton, 2011) and reaffirms for professionals working within this area of practice the ambivalence and anxiety about state interventions into the family.

2.9 Sharing Information and Working Together

The sections on information sharing and confidentiality (p.12 -13) are retained with an additional section included for social workers (taken from the BASW code of Ethics 1986). The sections pertaining to social workers and health visitors emphasise the need to both share and to keep information

confidential. Both also emphasise individual responsibility in making the 'justifiable' decision to either withhold or share information.

As with the 1988 document, outside of procedural guidance for investigating abuse there is little detail about the mechanics of interprofessional working. Again, there is a greater emphasis on agency agreements and protocols and on the benefits of joint training (Part 7, p.53 -55). References to health visitors as individual professionals follow a similar pattern, with social work largely subsumed under the title of their employers -social services departments and the National Society for the Prevention of Cruelty to Children (NSPCC). Health visitors are again identified with the supportive preventative role (p.18) and surveillance (p.19) with similar language to the 1988 guidance used to describe their roles.

2.10 Working Together 1999

The publication of Working Together to Safeguard Children in 1999 (DOH 1999) followed the election of a Labour government in 1997, and the beginning of a shift in policy towards a more developmental approach in child welfare policy (Glass, 1999). The guidance also followed on from research and commentary on the implementation of the Children Act 1989, some of which had been critical of aspects of the way in which the guidance was put into practice. Parton (2011) cites a number of potential influences on the revised guidance including concerns that the family support services intended by the Children Act 1989 had been patchily implemented, and that there was an over focus on identifying risk of significant harm at the expense of help

(Frost and Parton, 2009). The Children Act Now: Messages from Research, published in 1995, had also drawn attention to precautionary approaches to working with families that appeared to dominate social work practice at the time (Bullock et al 1995).

Parton (2011) draws attention to the use of the word ‘safeguarding ‘in the title to the guidance and claims that this is the first time that the term was used in official guidance (p.9). The use of this term signals a move away from more residual models of child welfare and ‘refocuses’ attention on the wider responsibilities placed on local authorities under Section 17 of the Children Act 1989 (Frost and Parton, 2009). The publication of the Framework for the Assessment of Children in Need and Their Families (Department of Health 2000) in draft at the same time as Working Together 1999 (it was also incorporated as an appendix into the guidance) complemented this more developmental approach.

2.11 Social work and Health Visiting in Working Together 1999

The document, 101 pages long, follows a similar pattern to its predecessors, but with some significant additions. The first section is entitled ‘Working together to support children and families’ (DoH 1999) and sets out the basis for seeing child protection as part of a continuum of support for children and their families. Part 2 ‘Some lessons from research and experience’, offers definitions of abuse, but unlike previous guidance also describes the impact of different forms of abuse. Mirroring the ecological approach to understanding child maltreatment found in the Framework, Part 2 looks at the wider

influences on children's well-being. For example, under the heading 'Sources of Stress for Children and Families' (p.8) there is a list of factors, described in detail, that make parenting difficult and have direct and indirect influences on children and young people. These include Social Exclusion (incorporating poverty, racism and other areas of disadvantage), Domestic Violence and Drug and Alcohol Misuse (DoH 1999, p.9).

This wider approach to child welfare has implications for the approach that professionals are asked to adopt to work with families. Those working with children are asked to:

'consider the wider needs of children and families involved in child protection processes, whether or not concerns about abuse and/or neglect are substantiated'
(DoH, 1999, p.11).

As with the previous guidance, social work is largely subsumed under the responsibilities of the social services department. At the time of the publication of Working Together 1999, the Care Standards Act 2000, which gave protection to the title social worker, was being drafted. Given the reification of the role of social workers that this represented it seems odd that social workers, still implicitly the key professional in child protection work, should be so anonymous within this guidance.

Health visitors are given a more prominent role than previously. For the first time their identity is separated from midwives and school nurses and their primary role clarified:

‘The primary focus of health visitors’ work with families is health promotion. Like few other professional groups, health visitors provide a universal service which, coupled with their expertise in assessing and monitoring child development, means they have an important role to play in all stages of family support and child protection. Health visitors are often the starting point for child protection referrals and their continuing work in supporting families places them in a unique position to continue to play an important part as enquiries progress’
(DoH 1999, p.20)

2.12 Working Together 2006

The 2006 guidance was issued after the Children Act 2004 and following the development of the Every Child Matters policy. This in turn followed from the death of Victoria Climbie, and the subsequent enquiry by Lord Laming that produced a large number of recommendations (Laming 2003). The latter signified a complex and large policy initiative that took in a range of government programmes, including Sure Start, and culminated in the Children Act 2004. The document is 256 pages long, including the bibliography and appendices, and is divided into two parts. Part one is identified as ‘statutory

guidance', and part two as 'non-statutory guidance' and there is an attempt to define and distinguish between the two categories within the document itself.

There is a chart at the beginning of the document that guides professionals to different chapters according to their role and responsibilities. For example, people who care for children are 'required' to read chapters one and two – which relate specifically to the background to the new guidance and to the roles and responsibilities of those involved in child welfare. The intended audience for the document is broader than previous iterations, echoing the all-encompassing and more developmental approach within the Every Child Matters policy. The guidance refers readers to a large number of other documents that provide more detailed or additional guidance, including 'Sharing Information: Practitioner's Guide' which lays out the legal permissions and restrictions on the sharing of information between professionals. The booklet is divided into 'Statutory' and 'non-statutory' guidance, the latter forming four chapters in the second half of the document. In addition, there are six appendices that include a guide to acronyms used, the Framework for the Assessment of Children in Need, and contacts for child protection within the Ministry of Defence.

2.13 Working Together 2010

The 2010 publication follows a similar format to its 2006 predecessor, with more elaboration of guidance in an expanded publication. The 2010 document was notably criticised in the Munro report (Munro 2010) for its size and complexity. Concerns were raised about the possible lack of utility of a

document that was so large and prescriptive that practitioners might fail to see the wood for the trees in making sense of the guidance (for example Parton, 2014). The culmination of this criticism, along with the work of the Social Work Reform Board and the Munro Review (as well as a change in government to the Liberal Democrat and Conservative coalition) led to a much slimmed down version of the guidance in 2013, which was again revised in 2015.

2.14 Working Together 2013 and 2015

The key changes in the 2013 document were the slimming down of mandatory guidance and the push to simplify the assessment process within the safeguarding system. Parton (2014) points out that there was a wholesale abandonment of the Every Child Matters policy framework, shifting the weight of the guidance towards a less developmental and more residual (Hardiker et al., 1991) model of child protection. Parton (2014, p.133) suggests that the location of safeguarding within the family, and the concomitant need to work in partnership with families, was partially abandoned here, with a renewed focus on ‘child rescue’. Parton links this with the ‘neoliberal agenda’ that he detects in government child welfare policy. He also points out that much of the reduction in the size and scope of the 2013 document was achieved by making copious links to other guidance that professionals could only obtain online. Dugmore (2014) challenges what he sees as a lack of appreciation for the complexity of practice and decision-making within the document, with a focus on getting the assessment and the decision-making completed as quickly as possible. The roles of social workers are noticeably sharper and more central in these two iterations of the guidance, with health visitors and

other professionals subordinate in the decision-making. Health visitors have far fewer direct references as a profession and their tasks are mostly confined to identification and information sharing.

2.15 The impact of perceived failures within practice

Identifying deficits in organisations and in individual professional practice became of central focus of public inquiries from the 1980s onwards, although this was not restricted to inquiries into child deaths (Stanley and Manthorpe, 2004). These twin areas of investigation can be characterized as worry about system error (organizational failure) and worry about operator error (individual failure). The character as well as the technical competence of professionals became the focus for debate within inquiries and within the media (Stanley and Manthorpe, 2004, Smith, 2001). This contrasts with the focus on societal explanations for abuse and neglect within the Colwell enquiry (Murphy, 1995) but also reflects a wider shift away from trust in professionals in health and social care and their judgment (Smith, 2001, Checkland et al., 2004). The focus on individual failings in child abuse may have a scapegoating effect in that it creates an account that places blame on professionals either for their incompetence or their poor character. This may free society from the need to examine the structural factors that might be present as causal influences within these cases (Reder et al., 1993; Hallet, 1989). An example of this are the high rates of domestic violence, mental health issues and substance misuse in cases where children have been seriously injured or killed (Brandon

et al., 2009). Effectively addressing a culture of gender based violence, and the widespread neglect of children are complex and challenging issues for societies to confront, not least because these issues may not fit well with a societal perception that the less powerful and vulnerable are cared for and protected. Scapegoating of professionals in individual cases might go some way to resolving the dissonance that child deaths create.

2.16 Loss of trust in professionals

Parton (1998; 2009) cites a movement away from trust in professional to 'confidence in systems' in the latter part of the twentieth century and the early part of the twenty first, in parallel with the rise of managerialsim. Smith (2001) suggests that the traditional relationship of trust between social workers and service users is marginalized within current policy discourses. She suggests further that this limits the possibilities for the development of trusting relationships in practice, as trust becomes crowd out by processes and procedures. Checkland et al (2004) note a similar tendency within medicine, whilst questioning the perfectibility of systems to prevent lapses in communication and errors in practice. All of these authors argue that attempts to build failure-proofed systems are flawed, and that they simultaneously undermined client trust in professionals and set the conditions for scapegoating and blaming cultures within organisations. As identified in the introduction to the thesis, O'Neil (2002) places a wider context around the loss of trust in professionals and the emergence of more reductive and procedural forms of accountability.

2.17 The Rule of optimism

Dingwall et al (1995) write about ‘the rule of optimism’ as a way of characterizing what they see as a tendency for social workers to over identify with parental needs at the expense of children’s safety. Focus on the character of carers deflects attention from the impact of parenting on the child. They suggest two components (discourses) relating to parents - cultural relativism and natural love. (p.94) ‘Parental incorrigibility’ (p.92) and ‘failure of containment’ (p.96). The common interpretation of optimistic bias in much of the literature is that Dingwall et al are referring to an overly rosy outlook for families, almost wishfully hoping that things will turn out well. Here the emphasis is much more clearly on the push from policy towards the protection of the idea of the family, with a strong cultural, rather than professional, bias towards the sanctity of the family. Only when the moral inadequacy of the parents or carers is exposed should the state intervene harshly, and in those instances the more facilitative elements of the child protection system become more rigid and ‘quasi-legalistic’:

> ‘The child protection system has not been colonized by law: rather the present mode of governmentality, the interlocking system of ideas and institutions that constitutes the cultural ordering of society (Foucault 1979; Burchell et al. 1991), treats law as its most powerful instrument of legitimation (cf Dingwall 1994b)’
> (Dingwall et al, 1995, P. 254).

2.18 Health visiting and trust

Peckover (2002)suggests that there is a resistance within the literature to acknowledging the surveillance role that health visitors play in the relationship between the state and the family. As with social workers, Peckover identifies the building of trusting relationships as a key to the effectiveness of the health-visiting role. The universal nature of health visiting in the UK, where every new born baby is offered at least one home visit, means that, in contrast to social work, the giving and receiving of advice is normalized as part of early parenthood. Peckover (2011) points to the gendered and quasi-medicalised nature of the profession as enabling factors in making intrusions by health visitors into the family home acceptable to mothers (although not all appointments take place in homes). She characterizes the stance of the health visitor towards mothers as a befriending one. However, the befriending role also acts as an entry point for non-coercive surveillance.

Peckover goes on to suggest that mothers actively resist the surveillance aspect of the health-visiting role. She uses domestic violence as an example of this (Peckover, 2002). Where mothers of young children are victims of domestic abuse, help seeking can risk inviting scrutiny of the mother's own capacity to parent (Hester, 2011). Within the relationship with health visitors this may set up a tension within women between welcoming the practical and moral support on offer, whilst evading exposure as a 'bad mother' or as a victim. Resistant strategies include avoidance - being out for arranged

appointments for example - and the stage managing of the presentation of self and of the family home. They might also appear to be in denial about the impact of the violence itself, in order to evade the victim and bad mother categories. Child welfare professionals often interpret this stance as denial, marking a further failure to protect children by denying the threat that violence and control represent to their well-being.

Summary

This chapter explored some of the tensions and pressures within child protection practice including the shifting policy and guidance. The next chapter looks more specifically at the research on professionals working together and the application of discursive approaches to research in health and social care.

Chapter 3

Applications of discursive research methods to practice in health and social care

Introduction

This chapter will provide a structured review of the research literature that adopts a discourse analysis approach to practice in nursing and social work. Some of the literature is drawn from traditions of discourse analysis, in particular conversation analysis and ethnomethodology. Others have a more general focus on talk and language as a form of action (Harre and Langenhove, 1998). The chapter will explore some of the functions of language in defining and facilitating professional identity and professional power with health and social care.

3.1 Discourse analysis in social work research

Discourse analysis is well established as an approach to research within the social sciences (Potter and Hepburn 2007). Within social work and health research in the United Kingdom, the application of discourse analysis has been less evident (White, 2009). Although there are different approaches to discourse analysis (Wetherell et al., 2001) they all emerge from a social constructionist perspective (Gergen, 2008) and share a common tenet that social realities are shaped by language and interaction (Wetherell et al., 2001). Wetherell suggests that the distinctive claim of discourse analysis is that language is constitutive of social life, rather than just referential (Wetherell et al., 2001). That is to say that social realities are made and maintained

through language and interaction. The epistemological stance adopted by discourse researchers consequently challenges realist approaches to qualitative research. Rather than seeing participant's talk as representative of an underlying set of beliefs and dispositions; discourse analysis focuses on language as acts that can only be read in reference to the context in which they were uttered (Hall and Slembrouck, 2009). For discourse theorists, attention needs to be paid to how language is used as much as the semantic content (Taylor, 2003,Taylor and White, 2001).

Despite its prominence in social sciences research in general, the impact of discourse analysis within the social work literature has been limited. Although the empirical research base for discourse in social work is narrow, White (2009) cites a number of attempts to categorize the culture of social work in terms of competing or shifting discourses (McBeath and Webb 1991; Parton 1994; Webb 2006). In an earlier text (Taylor and White, 2000) the authors attempt to synthesize some of the methodological developments within discourse analysis over the previous decades and apply them to social work practice with families. As with Pithouse and Atkinson (1988), the emphasis is on exploring the constitutive role that language plays in case formulation and decision-making within practice. They draw on research by discourse theorists (Smith 1978; Potter 1997), as well as some researchers into social work practice (Hester 1992) to illustrate the application of a range of approaches to analysis.

The implications of this perspective for professional working in health and in social care is that status and position need to be 'worked up' or performed within day to day practices (Dingwall, 1977a, White, 2002, Potter, 1996). This working up of professional identity and professional power is partially accomplished by professionals through language (Hall and Slembrouck, 2009). A number of researchers have examined the ways in which language accomplishes professional identity within the context of health and social work practices. This chapter will draw on a selection of the small body of research in this area to illustrate how these 'microsociological' (Hall and Slembrouck, 2009) approaches can illuminate some of the less visible practices of health and social work.

3.2 Talk and case construction

In an early application of discourse analysis to social work practice, Pithouse and Atkinson (1988) examined the case-talk of social workers within an office setting. Taking an explicitly eclectic approach to their analysis, the researchers looked at the narrative of a social worker presenting an account of a family that she is working with to her supervisor. They identify three functions of talk within the supervisor-supervisee relationship. The first is the illumination of social work activity, which is 'otherwise unobserved' (p.185). Secondly, they suggest that the social worker establishes their 'goodness' within the interview through the provision of a 'good account' (p.185). Thirdly, the social worker presents a 'diagnosis' of the family that justifies or gives warrant to a particular course of action. Rather than a formal application of theory, they suggest that the workers account rests upon a 'moral tale of

family life' (Pithouse and Atkinson, 1988). They refer to these discursive practices as 'ethnopoetics' (p.184).

Within this case study, the account by the social worker relies on their rhetorical skills in pulling together a 'plausible story-line' (p.194) rather than their technical knowledge to establish what is happening within the family. The authors summarize the worker's representation of the family 'as an act of bricolage' (p.194) bringing together different pieces of information about the family to make a coherent narrative. The construction of a plausible narrative achieves the three functions referred to above, and in doing so also brings an order to the multiplicity of possible interpretations of the 'case': 'A problem or collection of problems is assembled and given consequences through the narrative ordering of 'case-talk'' (p.197). These skills, as much as technical skills and formal knowledge, 'are constitutive of the worker's expertise' (p.198).

Both the 'invisibility' of social work practice, and in particular home visiting (Pithouse, 1998) and the constitutive function of professional narratives are key issues here. The social work account does not simply reflect the case, but also 'makes' it. The invisibility of practice can be seen to add to the social work professional's power, as they hold a dominant role in constructing a narrative that is hard for others, in this case the supervisor, to challenge. The telling of the story of the case therefore has a double function: ' It is a complex construction in its own right; it also stands for work in relation to unobserved encounters' (Pithouse and Atkinson, 1988).

3.3 Talk and case construction in multi-disciplinary work

In a slightly later study, writing within the context of multi-disciplinary work, White (2002) looks at the way that language is used to establish legitimate boundaries to professional areas of responsibility and expertise. Here the author focuses on the indeterminacy of diagnosis and case classification in an interdisciplinary setting and considers how 'different linguistic devices are used to signal particular readings of the case' (White 2002, p.413). The categorization of the presenting mental distress of adolescent patients as having either social or biomedical causes has a number of consequences. Firstly, it determines the ownership of the 'case', with psychosocial causes placed in the arena of social work, and medical causes being retained as the province of doctors. Secondly, White suggests that the telling of the story of the case has a moral force in establishing and distributing blame and responsibility for the presenting problems (White 2002, p. 416). She suggests that narratives are constructed using rhetorical devices such as 'extreme case formulation' (Pomerantz 1978) to foreground or downplay characteristics of the 'case' and establish whether parents are 'guilty' or 'innocent' of causing illness to their children, and whether they are 'hopeful' cases where change may be achieved or 'entrenched and hopeless' cases which might justify controlling or dismissive responses in professionals. White emphasizes that these strategies both enable and legitimize professional power, whilst at the same time they allow workers to fend off anxieties about blame and powerlessness to effect change in the lives of service users.

3.4 Formal meetings

Hall et al (2006) looked at the way that case formulation enabled decision - making within a child protection conference. Writing at a time when the child protection register was still in operation, they considered the ways in which the identity or character of the mother of the children being discussed is established within the professional discourses. As with White, they note that the main focus of discussion is the capacity of the parent to care for the children, rather than the welfare of the children themselves:

> 'The nature of description and evaluation in the meeting is organized around the depicting the mother's character, rather than focusing on the nature of the abuse the children have faced' (Hall et al 2006, p.56)

Characterizing the mother, and establishing through this characterization her capacity for change, then becomes essential to the decision-making for the case. The authors identify three processes at work within the conference. Firstly, the professionals 'work up' the character of the mother through the use of contrasts. These can operate both as external contrasts – for example comparing the mother against a hypothetical social standard of parenting – and internally contrasting the mother's 'good' qualities with her 'less good' ones. Secondly the process of characterization is consensual, although not without debate or disagreement leading up to the decision-making. Thirdly, the process is cumulative with each professional assessment building upon, and refining, the previous ones (Hall et al., 2006).

These processes are significant in the context of interprofessional working. The authors suggest that although the direction of the conference is towards a consensus, disagreement and the development of different perspectives is also allowed:

> ‘Character assessments are developed consensually with each professional appearing to agree with the previous one, but then making refinements which hint at slightly different depictions’
> (Hall et al., 2006p. 68 -69)

Although there is some element of competition in the professional accounts, as in White’s example, there is also a convergence of accounts that establishes the case and creates a warrant for further possible action. One point of different between the two pieces of research is the place in the referral and intervention process. The professionals in White’s study are competing over case allocation. In Hall et al’s work, the need to undertake professional boundary work is not so apparent. Key themes emerge from these pieces of research. One is the role that language plays in helping to construct both the case and boundaries of professional identity.

3.5 The role of talk and storytelling in the production of professional identity.

Dingwall (1977) provides examples of the process of identity construction for professionals. In his study, of student health visitors, he suggests that practitioners develop stories that help to provide a cohesive sense of professional identity both for the individual and the group. Dingwall identifies threats to professional identity in two directions. For health visitors he suggests that there is a threat of exclusion from a medical role with children and families from the more established and structurally powerful doctors who work in the community as General Practitioners. A second threat, that of inclusion (or assimilation), arises from social workers where some commonality of practices and client groups leads to a threat of blurring of a distinct professional identity.

One approach used to counter these threats is the use of ‘atrocity stories’ (Dingwall 1977). Dingwall suggests that these take the form of accounts that represent both the teller (in their professional role) and a member of the professional group that threatens inclusion or exclusion. The work that is done by these stories is the establishment, or positioning, of the teller as competent and heroic and the ‘other’ as incompetent or possibly treacherous or bizarre. An example given by Dingwall is a story recounted by a tutor who describes her efforts to support a parent who was worried about her young child’s hearing. The tutor describes how she supported the parent in her frustrated attempts to get her GP to understand her concerns about her child.

Dingwall points out some common themes in the stories that are told and links these to the discursive struggle by the health visitors to attain equality with the doctors. He suggests that the stories also function as a template for correct behaviour for the students (Dingwall 1977, p.34). Dingwall characterizes the atrocity stories as constituting part of a struggle for autonomy from and parity with GPs, but they also perform the functions of reifying and mapping the identities of the speakers. Significantly this has the effect of establishing identity for the individual, but also for the 'community of practice' (Wenger, 1998) of health visitors. Dingwall draws attention to the particular significance of this to professionals in training, where the processes involved in forming a professional identity may be more explicit and fore grounded. White and Featherstone (2005) provide evidence that this process is also present in constructions of own and other professionals in day-to-day settings. Their research took place within the context of a multi-disciplinary child and adolescent mental health team, where the anxieties about inclusion and exclusion might be expected to be present.

3.6 Professional narratives in interprofessional work

The co-location of workers from different professions but with common client groups has been driven by policy directives within the UK (Frost et al., 2005)and is progressing in all areas of health and social care. There is some scepticism about the desirability or efficacy of this process from commentators and professionals (Reynolds, 2007). White and Featherstone (2005) ask us to pay attention to development of narratives about the nature of different

professions and how these construct an identity both for the professional telling the story and the 'other'. Linked to this are the discourses of professional identity. The authors identify a struggle to engage with sameness and difference between professions. They suggest that key to the establishment and maintenance of professional purpose, justification and power.

In White and Featherstone's study both the 'surface' and 'depth' of the relationships are considered with contrasts drawn between the stated desire to make 'working together' work, and a range of rhetorical devices employed to create difference and identity in relation to 'other' professions. One example of this is in the way that decisions are made about allocation of cases to different professionals within the team. White and Featherstone document the ease with which a psychiatrist and social workers work up different, but equally plausible accounts of the same referral, and in doing so apportion moral responsibility for the often inadequate response to need (2005: p211 - 212). They cite the 'malleability of diagnostic categories' (p.211) and the 'ambiguity' (p.212) of cases as important features of the everyday negotiations between different disciplines within the setting. This indeterminacy gives rise to a need to claim or reject referrals as being owned by one discipline or another, which in turn creates a discursive space for the formulation of identities:

> 'Through claiming or disclaiming case, moral aspects of professional identity are performed, transmitted and reproduced.

> Talk about cases thus helps to differentiate particular identities from those of allied occupations and inducts novices into aspects of the tacit dimension of their particular domain'
> (White and Featherstone 2005: p.212)

White and Featherstone do acknowledge the continuity of identity between professional groups and between individual professions, with a shared desire to place the welfare of children at the centre of their concerns. They also point out the heterogeneous nature of professional groups, and the tendency to align along associations of friendship, gender and other characteristics. However, they challenge the view that structural changes in terms of co-location of workers and efficiency of resource allocation are sufficient to make significant changes in collaborative practices (p.215). They also go beyond the idea that improved training in communication skills, along with an often repeated exhortation to communicate more effectively, will in themselves improve interdisciplinary working, although they acknowledge these as key components of a necessary change. Primarily though, they are focused on the need to take a more reflexive stance in relation to professional identity, and to abandon entrenched views about other professionals:

> 'To do so would require an examination of their own rituals and stories as well as those of others. Cultures have the capacity to sustain forms of professional reasoning which function as situated forms of common sense'
> (White and Featherstone 2005, p.215)

One implication of these ideas about how professional identity is formed and sustained is that oppositions, and by extension misunderstandings, will persist as long as myth making and storytelling about self and others within professions remain unexamined. However, the implications extend beyond identity into the construction of potentially discordant discourses about the 'reality' of children's lives. White and Featherstone draw attention to the implications this may have for projects such as the common assessment framework, where assumptions might be made about commonly held meanings and values attached to language. Rather than creating or affirming a common ground when making decisions about families, these instruments may elide or disguise differences in interpretation or emphasis.

3.7 Professional talk and the creation of new professional identities

Reynolds (2007) looked at the way that health and social care professionals constructed versions of their colleagues from other professions. Reynolds analysed submissions to an online forum that ran as part of a professional course in health and social care. Participants came from a variety of professional backgrounds within health and social care. Part of the findings focused on the process of 'othering' that Reynolds detected in the language of the participants. Drawing on Davies' (Davies, 2003) observations on the use of binary positions as a part of identity formation, Reynolds considers the apparent contradictions in accounts of interprofessional working. She identifies a tension between the need to work-up positive accounts of 'working

together' whilst maintaining distinct professional identities. The tension between the two imperatives gives rise to 'contrastive rhetoric' (Reynolds, 2007), and atrocity stories, echoing Dingwall (1977). The issues of assimilation and differentiation that Dingwall identified are echoed in her findings. Reynolds concludes that new working arrangements produce new professional identities that might engender discourses of continuity with other professionals, rather than difference. However, she sets this alongside the development of new processes of othering as well. So professional identities might develop along new lines of similarity, for example in multi-disciplinary community based teams. But so can lines of differentiation – between community and hospital based services, or between medical and social care focused services.

3.8 Talk and professional 'boundary work'.

In an ethnographic study of nurses working within a hospital setting, Allen (2001) considered some of the ways in which 'boundary – work' was accomplished by staff within their talk. Allen's study used transcripts of naturally occurring speech, and semi-focused interviews, to illuminate the ways in which narratives can be used to establish and maintain jurisdiction. Focusing on the division of labour between doctors and nurses, Allen identifies the use of atrocity stories but rejects the idea that they can be interpreted as a proxy for a psychological process, as Dingwall suggests. Instead she identifies the ways in which the stories work to establish differences between nurses and doctors at a social level. To this end, she

suggests that the social location of the telling - nurse to nurse rather than nurse to doctor – is important:

> ‘In addition to constructing social difference between the occupations of nursing and medicine rhetorically, the pattern of nurses’ storytelling simultaneously constitutes membership of the nursing group’
> (Allen, 2001; p.92)

Allen identifies a number of rhetorical devises used by the nurses is to establish a professional boundary. In one case example, Allen presents the recounting of a story of the death of a patient on a night shift. The nurses involved make reference to a technical term – Cheyne Stoking – that signifies the imminence of death. A doctor in the story fails to understand this term and is criticized for her failed diagnosis as a consequence. The use of specialist language is identified by Allen as a ‘claim to knowledge’ (Allen, 2001); it could equally be seen as a claim to a category entitlement (Potter, 1996). The latter allows the speaker to establish the primacy of their expertise over the ‘other’ – in this case the doctor. In this instance the portrayal is directed towards the blurring of professional boundaries. The nurse’s claim to knowledge requires the doctor to recognize her as at least an equal in her diagnostic skills. Other accounts function to reinforce or establish boundaries. Allen identifies some of these as functioning to establish moral or ethical distinctions between the two professions. The claims to values by the nurses in the study come from two directions. Firstly, the place of nurses in the structure places them closer to

the everyday care of the patients. This gives rise to claims to a holistic view denied to doctors. Secondly, the nurses make claims to superior communication skills and greater empathy with the patients (Allen, 2001, p.94).

Allen makes two other significant suggestions in the article. Firstly, after Chambliss (1996), she suggests that what might appear to be ethical differences between different professions could be a cover for territorial disputes. Secondly, Allen suggests that the shared interpretive repertoires that the nurses incorporate into their storytelling may have arisen from the particular political and managerial debates taking place at the time of the research. At the time of the research, there was a debate in the UK about the professional direction in which nursing should develop (Meerabeau, 1998). One aspect of this debate was about whether the care role of nursing would be undermined by a focus on developing the profession through increased technical expertise. Allen draws a parallel between this debate and the rhetorical struggles in the nurses' accounts (Allen, 2001). She suggests that the nurses embraced both in the working up of their professional identity.

3.9 The language of professional judgment

Traynor et al (2010a), used the tension between technicality and indeterminacy as a frame for analysing the talk of nurses. Their starting point was the dilemma identified by Jamous and Peliolle (1970) faced by professionals attempting to gain or maintain status for their profession. They theorize that professional identity is formulated by a combination of technical

knowledge and professional judgment. However, there are threats to professionalism if a particular group becomes too identified with either quality. Technical knowledge is attainable to other professionals or non-professionals (such as administrators), and claims to judgment, drawn from experience or a particular set of values, are required to shore up a professional identity. Claims to judgment are vulnerable to suggestions of particularism and inconsistency and require support from a body of technical knowledge to maintain a defined professional status.

Using focus groups drawn from experienced nurses on a professional development course, Traynor et al explored the language used to account for non-technical forms of decision-making in day-to-day work (Traynor et al., 2010a, Traynor et al., 2010b). Their findings suggested that the nurses in the study drew upon professional discourses to fend off the threats to autonomy and professional credibility identified by Jamous and Peliolle. They told stories about their work that emphasized the indeterminate nature of the work. This in turn required an element of judgment in their decision-making that could not simply be ascribed to a body of technical knowledge. Moreover, the study suggests that the nurses based the legitimacy of their professional discretion on moral necessity:

> ‘In this clinical nursing discourse, autonomous decision-making is legitimized by a moral obligation towards the patient rather than by drawing on a unique body of explicit professional knowledge’ (Traynor et al., 2010b; p.1511)

The ‘‘decision-making’ repertoire’ (p.1511) is represented within the nurses’ stories as alternative outcomes that result in either ‘professional subjugation or successful nursing action’ (p.1511). Good outcomes thus come to mean ones in which the nurses wrested professional autonomy from others. The authors suggest that the nurses in the study use stories about their work to position themselves as ‘heroic’, struggling against bureaucratic limitations and the limited perspectives of medics (doctors) to get the best deal for their patients. This in turn functions as a reification of professional autonomy, based primarily on ethical obligations rather than technical knowledge.

The explicit claim to values made within these accounts shares features with the contrastive rhetoric that Reynolds (2007) identifies. In her research, however, the moral positioning is dependent on the establishment of competence to work within the systems and structures that define good practice. For example, the speed and efficiency of moving patients out of hospital settings is cited as a measure for effectiveness. In Traynor et al’s research, moral adequacy, or even superiority, is established through the obligation to place the needs of patients above a straightforward compliance with procedures. In some respects, the willingness to define professional identity against the system of care in this way suggests a radical autonomy within the professional identity of the nurses in the study. The researchers suggest, however, that this may represent a ‘ fantasy of professional autonomy’ (Traynor et al., 2010b) rather than a reflection of practice.

3.10 Accounting for professional power and the struggle to be 'good'

Svensson (2009) explored the way that a variety of social care professional negotiated the tension between control and support in their work. Svensson's study looked at three groups of Swedish workers in different parts of the welfare system. She considered the extent to which issues of control were present within their narratives about their work with people receiving state services. Drawing on socially constructionist theories of identity (Tilly 2002) Svensson examined the struggle that workers undertook in order to establish a 'good' identity for themselves in accounts of their work. She suggests the term 'caring power' (van Drenth and de Haan, 1999) to incorporate the care and control aspects of social work (Svensson, 2009). Although caring power is presented as a 'good', Svensson see the incorporation of the two elements into social work identity as being problematic for practitioners.

In her study, she examines the accounts given by three groups of social care professionals, working in three distinct settings, of their role in relation to service users. She suggests that there are three distinct approaches taken by workers to the issues of control in the accounts of their work:

> 'These can be summarized as ignoring, separating and rewriting and they are connected to the levels of visibility of control in the different settings'
>
> (Svensson, 2009; p.242)

The ignoring of control is most possible in areas of work where control is least visible. In this case the 'implicit' (p. 245) control within the victim support role is hidden and so more easily ignored. Svensson describes the separating of control and care as occurring within the role of statutory social workers with children and families. In this case the care is attributed to the social worker whilst the controlling function is split off and located within the social work organization. The third account is present where the control function is most explicit – in Svensson's study this was in a probation service. Here, she suggests, the control function is rewritten as being support. Consequently, the power to punish and override the autonomy of service users within the service is not attended to within the probation workers' accounts (p.244).

Svensson argues that the dilemma that provokes these discursive strategies is the difficulty of reconciling a 'good' professional identity with having control over the lives of the people that use the services provided by the workers. She links this with two other aspects of social work identity. Firstly, although social work usually exists within the context of an organization of some kind, Svensson notes the tendency for the workers in her study to define their roles in opposition to the organizations that they work for. This highlights a logical contradiction for professionals attempting to disavow the controlling aspects of their work while drawing on an organizational mandate for their interventions. There is an explicit denial of authority whilst simultaneously employing it as a tool. The second point that she suggests is that social work has a tendency to define itself in terms of intrinsic qualities rather than enacted ones:

> ‘The important thing is to reflect upon what it means if social work is understood more as ‘being’ than ‘doing’ and we can see a tendency to regard being in positive terms’
> (Svensson, 2009;p.245))

Svensson cites the emerging interest in virtue ethics (Clark, 2006, McBeath and Webb, 2002) in social work writing as an example of this focus on being rather than doing. Within virtue ethics emphasis is placed on the character of the moral agent, rather than a system of moral or ethical decision- making per se. Svensson argues that a focus on being might allow professionals to ignore the controlling aspects of their work, as well as their implicit relationship with powerful institutions. She suggests that the workers in her study are constructing an ideal of professional identity – the ‘good’ worker - that is incompatible with the idea of controlling clients. There is some continuity here with the Traynor study (Traynor et al., 2010b)where the nurses worked up of identity in contrast to the organizational structures that enable the work.

Similar issues about the visibility of control within social work emerge in research by Banks and Williams (2005). The authors set out explore practitioner accounts of ethically difficult situations (Banks and Williams, 2005). They were particularly interested in ‘ethics talk’ (p. 1009) including the formal and informal references to ethics drawn upon by the practitioners (p.1010). The accounts, drawn from interviews, are treated as both as reflections of experience and as constructions:

> '…subjects reflexively construct their own identities as competent, ethical, professional practitioners – as certain kinds of people who possess certain kinds of character traits and behave in certain kinds of ways'.
> (Banks and Williams, 2005; p.1010)

As with Svensson, Banks and Williams note that some available identities are more apparent in the accounts than others. For example, one child protection worker provides an account that positions her as 'sensitive and caring' (p.1020). This contrasts with her account of her organization as procedural, insensitive and oppressive (p.1013). The authors also note the absence of moral agency in the account by the worker – as if moral choice had been removed from her.

3.11 Care and control in health and social care

Debates about care and control are well rehearsed within the social work literature (Parton, 1991,Dingwall et al., 1995). Payne (2006) suggests that some degree of social control is always present within social work practice. He suggests that there are three discourses of social work that exist in tension with each other in all areas of work. The dimensions that identifies are therapeutic, social order and transformational (Payne, 2006). In Payne's view the three approaches both compete with and complement each other, and their particular configuration will depend heavily on the context of the work undertaken. In mental health teams for example there may be a balance between each of the elements with a social order role (detentions under the

Mental Health Acts) therapeutic and transformational (challenging societal assumptions about the nature of mental illness) coexisting within the work. In child protection work there may be more emphasis on social order and therapeutic approaches, with less freedom to challenge structural inequality.

The Codes of Practice for social workers in England (General Social Care Council 2010) reflect some of these tensions. Sections three and four deal primarily with upholding the rights of service users – including the right to autonomy- whilst protecting the service user and others from harm. The apparently paradoxical nature of these two injunctions represents a clear dilemma for social workers. Protection of service users and the general public are likely at to be at odds with the need to promote the rights of individual service users to take risks and to make decisions autonomously (van Nijnatten et al., 2001). The dilemma is particularly apparent within child protection work where the rights of children and young people are often seen to be in competition with those of their parents or carers. The British Association of Social Workers (BASW) code of ethics (BASW 2011) contains similar twin injunctions about the need to uphold rights whilst protecting others. However, there is much more emphasis on the need to promote and facilitate autonomy and social justice. Within the literature generally, anti-oppressive practices are seen as core to the profession (Dominelli, 2002, Thompson, 2006)and are valued by social workers (Cree and Myers, 2008). Controlling or limiting service user autonomy is not so explicitly valued and is likely to be seen as dissonant with the discourses of empowerment and rights.

3.12 Negotiating support and coercion

Van Nijnatten et al (2001) looked at the way social workers in The Netherlands negotiated the formal and repressive aspects of their role with families subject to supervision orders. They analysed video recordings of interviews between workers and families using conversation analysis. In the Dutch context, supervision orders are issues by the family court in case where there are serious concerns about the welfare of a child (van Nijnatten et al., 2001). The order places an obligation on the family to accept support and care for the child. The authors locate a dilemma for workers attempting to intervene effectively with families under these circumstances:

> ‘Family supervision represents, first and foremost, a controlling function, backed by legal authority, and the power to intervene in family life. At the same times it embraces the helping and supporting role of the family supervisor, aimed at improving the child’s situation. In other words, aspects of care and coercion are inextricably linked here.’.
>
> (van Nijnatten et al., 2001; p.159)

The authors suggest that there is a significant difficulty for the workers as they attempt to synthesize the controlling aspects of their work with the technical and value base of their profession. In the latter co-operation with families is seen as the most ethical and the most effective way of working with them (Shemmings and Shemmings, 2001, Thoburn et al., 1995). However, attempts to form partnerships with service users are threatened by the coercive nature

of the intervention into family life. The authors used an analytical approach drawn from ethnomethodology (Sacks et al., 1974) to identify the strategies used by the workers to respond to these dilemmas.

The article identifies four distinct discursive approaches to issues of authority, with only one approach defining the worker's role in terms of her mandated authority from the courts. As with Svensson, the three more commonly encountered discursive devices either hide authority in some way or locate it elsewhere. The authors emphasize that this work is done rhetorically through the use of language. In one example a worker accounts for their presence within the family by describing and delimiting their role as 'just a family supervisor' (p.715). Disagreements from the family members about the nature of the intervention have to be 'taken up with the court' (p.715). Another strategy involved stressing commonality and cooperation within the relationship by establishing broad goals that the worker and the service user could identify with –for example the best 'interests of the children' (p.714). The third strategy that masked or denied authority was being non-specific or making indirect references to authority (p.711).

In their discussion the authors account for these 'vague' accounts of authority in terms of the particular welfare ideology that have been dominant in the training of Dutch social workers (van Nijnatten et al., 2001). They suggest that the discursive strategies employed by the workers enact a masking of difference and enable an ideal of 'partnership and equality' to be established in the relationship (p.717). A secondary effect of this is the avoidance of conflict,

which may be seen as a barrier to cooperation, and consequently a barrier to the effectiveness of the supervision order. The authors suggest that the avoidance of conflict may be associated with a lack of skill or confidence in dealing well with it. However, as with Svensson (2009) and Banks and Williams (2005), the struggle to work up a ‘good’ identity for the worker is also present.

Summary

There are two important common themes within the research that has been examined here. One is methodological and relates to the ways in which it is possible to ‘know’ about the exercise of professional power within the closed off and partially obscured settings for much health and social care work. The second theme relates to the way in which language enables the construction of professional identities and reflects some of the dilemmas that face professionals as they try to construct a ‘good’ identity for themselves.

Pithouses’s contention (1998) that social work is an ‘invisible trade’ throws up a question about the extent to which social work can be ‘known’ and measured. A similar view has been suggested of the role of health visiting (Robinson, 1998). Two broad approaches have been adopted in the research discussed here. The first is the recording and analysis of ‘natural occurring talk’ in the form of direct observation of the interactions between different professionals and between professionals and service users. The second approach is the analysis of workers accounts of their practice, either through interviews or observational accounts.

Hall and Slembrouck (2011) argue for the value of naturally occurring talk as a source for analysis. They suggest that where interview material is used care needs to be taken to account for the contextual and dialogical aspects of the production of meaning. In other words, they point out that it is too simplistic to say that interviews illicit only what people think, as the interviewer and the interviewee co-construct versions of reality within the interview process (Hall and Slembrouck, 2011). Similarly Taylor (2003) challenges the 'naïve realist' (p. 250) interpretations of reflections from practitioners as straightforward narrative accounts of their practice. Rather she suggests that:

> 'Rather than simply focusing on what is being said, we must also consider how things are said and think in terms of the way that reality is textually constructed'
> (Taylor, 2003)

The broad methodology adopted within the research lends itself to making visible some of the processes that Pithouse identifies as invisible. The focus on language allows the researchers to examine how professionals construct warrants for their interventions with families and individuals, and how they negotiate ethical and moral positions in relation to service users and other professionals.

This chapter provided a structured and selective review of the literature relating to the use of discursive approaches to researching health and social care

practice. Although within the available the literature the research base for this approach is narrow, discourse analysis provides a useful framework for understanding the ways in which language is used to construct versions of client and professional identities. This literature provides a starting point for understanding how health visitors and social workers might negotiate their accounts of ethical decision-making within their practice.

Chapter 4

Methodology

Introduction

The research questions emerged from an interest in understanding the ethical stances that health visitors and social workers adopt in joint working. I chose to look at a number of elements that were likely to contribute to the individual and joint stances of both groups of professionals as they worked together in child protection or child safeguarding work. The research questions mirror these elements, which in turn were drawn from a combination of my practice experience as a social worker, and as a social worker academic, and from the literature on values in practice, professional identity and interprofessional working.

Research questions.

The research questions guiding the thesis were as follows:

- How do health visitors and social workers talk about the ethical dimensions of their work?

- How do they approach ethical conflicts in joint working?

- Are there differences in the ethical priorities of the two groups?

The available literature in this looks at both conflict between professionals within child protection work and the elements of best practice in working with others (Woodhouse and Pengelly, 1991, Davies, 2003, Reder and Duncan, 2003, Atkinson et al., 2007). Although my interest lay in understanding the elements of conflict within the working relationships, I also wanted to look at the degree of continuity that exists within successful joint working and collaboration. Two authors, Davies (2003) and Reynolds (2007) particularly influenced my thinking in this regard. Davies talks about the emerging sense of continuity in workers in multi-disciplinary settings. Davies (2003) describes the degree of alignment between workers that might emerge within teams of mixed professionals and suggests the development of identities formed around shared work and shared roles rather than individual professions. Reynolds (2007) extends this idea and tentatively suggests that shared work roles might overlay professional/occupational identities where workers share common tasks and organisational priorities. In Reynolds' study nurses on a continuing professional development course were asked to contribute to a web based discussion. Reynolds highlighted the issues of professional identification and the performance of professional roles that emerged in the debates and discussions that took place. Her emphasis on the role of language in shaping and reflecting accounts particularly interested me. Banks and Williams (2005) looked at the ways in which social work practitioners were able to account for the ethical dimensions of their work. They used interviews with workers and analysed the language that was used within the accounts. This small piece of qualitative research was also a significant influence on my

thinking at the early stages of the design as I looked to find an approach that captured the issues that were less well explored in the literature.

4.2 Research Design

The research design involved two small studies, both of which were intended to address the first research question - how do health visitors and social worker talk about the ethical dimensions of their work. Both studies contributed to the third question, are there differences in the ethical priorities of the two groups.

1. Use of a child protection case study with for social workers and health visitors to respond to.
2. Semi-structured interviews with pairs (or dyads) of social workers and health visitors that have worked successfully together.

The second question, concerned with how they approach ethical conflicts in joint working, is primarily addressed within the interviews.

4.3 Case Study (see Appendix 449)

The first of these made use of an online tool called the Values Exchange (Seedhouse, 2002, Seedhouse, 2005) which was originally developed by David Seedhouse as an online ethical decision-making tool. The intention in using this was to gain some insight into the different ethical priorities that

social workers and health visitors may have had in their independent decision-making. Participants were asked to respond to a fictional case study that included a child protection issue (see appendix 1 for the case study). The exchange is an open community based tool and can be accessed by anyone who signs up for the service. In order to exclude the data from general members of the public I inserted a filter question for my participants – 'are you a participant in Peter Jordan's research' – so that I could distinguish the two sets of responses. I also asked participants to identify whether they were either health visitors or social workers so that I could disaggregate the responses accordingly.

The case study was generated by me from my memory of cases that I had worked on. The case involved a family with two parents, one male and female. Both parents had a history of mental health problems and one had a learning disability. They had experienced the removal of two children from their care and were expecting a third child soon. The case was designed to be complex and as realistic as possible within the limitations of a fictional case. The layers of potential conflict –between the interests of the mother, the father and the child – were intended to produce a textured and provocative scenario that might elicit some of the contradictions and tensions that professionals encounter in practice. As per the protocol for the Values Exchange, the case study came with a proposal which was that the unborn child should be removed after it was born in order to protect the child from potential neglect. This again was a deliberately provocative element of the case

4.4 Recruitment for Case Study

Participants were recruited through meetings with social workers and health visitors. Additionally, some participants were recruited through continuing professional development events for social workers. The online tool is an open access site, designed to offer open debates with the general public about ethical issues and debates that occur in day to day life (Seedhouse, 2016). Participants were informed that they could use a pseudonym to conceal their identity when using the site, but most chose not to. Participants identified themselves by answering a filter question on the site.

The purpose of the case study was to examine the potential difference in responses to that might emerge. Some previous research has indicated that professionals from the two groups might hold some quite different attitudes towards child protection cases; in particular the relationships and judgements about parents (Cooper and Pennington, 1995). I also wanted to capture which ethical perspectives, or specific values, were highlighted by the different professionals. The Values Exchange allows participants to explore their priorities in making decisions about individual cases. For example, participants were encouraged to identify what course of action they would take (whether they agreed with the proposition to remove the child at birth) and then choose which values they sought to uphold by choosing that particular course of action. Free text boxes were also available for participants to comment on their decision-making and also offer alternative courses of action (if they chose to do so).

The open nature of the website meant that participants could potentially review and respond to each other – although only after they had completed the task. None of the participant in this study did so. Five health visitors (all identified as female) and nine social workers (four male and six female) volunteered to complete the study and all did so. The case study was piloted using the exchange prior to the live data collection. This allowed some potential problems with the instructions for logging on to the site and completing the task to be identified and remedied.

4.5 Data handling and data analysis

The data from the case study was primarily qualitative. The data from the free text boxes was reviewed and analysed using a bricolage of discursive elements. The quantitative elements of the data were used to provide descriptive statistics for the analysis. The group was neither representative nor sufficiently large to provide an inferential analysis. Not all of the participants completed the free text boxes, and this meant that some of the data from this section of the study was quite limited. However, some of the preliminary analysis from the case study did inform the later analysis of the interviews.

4.6 Approach to the Interviews

The qualitative interviews were designed to provide the bulk of data for the study. My intention within the design of the interviews was to capture reflective accounts of ethical decision-making between social workers and health visitors. I decided that interviewing in pairs would offer a particularly rich and

informative data set that could not be captured using other interview designs. I discarded the idea of individual interviews with social workers and health visitors for a number of reasons. The primary reason was methodological. Individual interviews about ethics and interprofessional working would have produced single accounts that would have replicated previous research (Woodman et al., 2013, Banks and Williams, 2005) effectively, but would not have generated the co-constructions of accounts that might occur within the dyadic interviews that I planned. In Woodman et al's paper they refer to the very different narratives that professionals generate about each other (2013). In this case, they were considering the perspectives of different health professionals on their relationship with the child protection process. Some of the findings showed that health visitors and general practitioners had very different perspectives on how well they worked together (Woodman et al., 2013). The accounts of the health visitors echoed some of the findings of Dingwall (1977a) in that they used 'atrocity stories' to highlight differences in their capacity and capability from their medical colleagues, whilst the GPs spoke very positively about the working relationship with the health visitors.

In Banks and Williams research (2005), the authors report rich data from individual accounts of ethical dimensions of their work. Replicating this approach would have met one of the aims of my study, to elicit reflections on ethical decision-making in practice. However, the interprofessional elements were an important part of the study, and although the interviews were 'artificial' environments for co-working, they could, potentially offer a different set of interpersonal dynamics to solo interviews.

I also considered the ethical dimension of the dyadic versus the solo interview. If, I intended, I was successful in recruiting participants who had worked together, individual interviews would have offered greater scope for rhetorical strategies, such as the telling of atrocity stories. There are many examples in the literature that explore the negative aspects of interprofessional working (Dingwall and Murray, 1983, White, 2002, Littlechild and Smith, 2013, Woodhouse and Pengelly, 1991) and the challenges that this generates. My interest lay in exploring the more successful aspects of interprofessional working.

I was aware from my own practice experience, and encounters with health and social care professionals as an academic, of the tensions and conflicts that social workers and health visitors had to negotiate in their day-t- day practice. My intention in recruiting pairs of professionals who had worked successfully together was to examine the formulations for successful working that the participants had available to them. In this way I hoped to add to the knowledge about how professionals negotiate relationships within this setting.

4.7 Recruitment for the interviews

As with the case study recruitment, I attended team meetings for social workers in several different districts of a rural local authority. I also attended one large area meeting for health visitors. At both sets of meetings there was polite interest in the research and an acknowledgement that there was some value in exploring the ethical challenges of their work and the interprofessional

dynamics. My aim was to recruit four dyads of social workers and health visitors and I was successful in doing this. The protocol for the research meant that if I recruited a health visitor, they would then speak with a social worker who would be given my contact details. The process worked in reverse as well, so that half the sample were recruited through the social worker first, and the other half through the health visitors. The protocol required that the pair had worked together successfully on at least one case. Across the four dyads, one had worked on one case together, but the other three had worked on multiple cases over a number of years.

All of the participants identified as female, and all had been qualified and in practice for at least five years. All identified as white British, and the age range was between 35 and 50. All spoke English as a first language.

4.8 Agency team meetings

When I arranged to attend the team meetings, I made sure that I had prepared a clear account of the research and was also prepared to answer questions about the studies. As I had been a social work practitioner in the area in which I recruited participants, I was not surprised to see one or two people that I had worked with previously at each of the four meetings that I attended. It was not clear what impact being known to some of the potential participants had on recruitment or on their contribution within the interviews. I did, however reflect on the positioning that my role as a social worker and a current social work academic, although not a well-known one, might have on perceptions of the research.

One notable feature of the recruitment phase was the willingness of the social workers and health visitors to share stories about their working relationships, informally, at the team meetings. It did not surprise me that both groups of workers were eager to tell stories about this, as it fitted well with both my experience and the literature on interprofessional working (Bell and Allain, 2011, Allen, 2001, Dingwall, 1997). As a group, the health visitors were more sceptical about the working relationship with social workers -with some laughing out loud when I suggested that they might be able to think of a case where their joint working was successful.

At the time of the research a joint protocol for working together on initial child protection and child in need assessments had been introduced. This meant that the majority of workers in both groups had recent experience of working with the other profession.

4.9 Ethical issues

There were a number of ethical issues that I was aware of from the beginning of the planning of the study, but, given the subject of the thesis, I wanted ethical issues to be at the centre of the research rather than as an addition later on (Miller et al., 2012).

The possibility of the participants having prior knowledge of me was raised during the ethical approval stage. However, none of those who took part in the interview stage of the research had been a colleague of mine previously.

Some of the participants in the case study exercise had been known to me as students on continuing professional development courses. As the participants completed the online activity in their own time I did not think this was a significant element of the recruitment.

For those taking part in the interviews I was aware that there might be strong feelings aroused about the subject matter, even though we were talking about issues that they were used to dealing with in their day to day work. I made myself available to speak to after the interview and gave the participants details of counselling and support services within their agencies if they needed to access these.

Duncombe and Jessop (2012) identify some of the ethical pitfalls of building relationships with interviewees in order to elicit information from them. I was aware of this danger during the interview, and became conscious, during the analysis that I might be replicating one of the ethical concerns that the workers had about the relationships that they developed with clients in practice. To guard against this I made as sure as I could that the participants were aware of their right to withhold or remove data after the interview was complete. I also spoke with them about the nature of the analysis, affirming that the interviews would not be seen as a 'window' into their inner selves; rather the language that they used would be analysed in relation to wider discourses of ethics and professional identity (Wetherell et al., 2001). No inducements were offered to participants and all offered written as well as verbal consent.

4.10 Ethical Approval

Ethical for the research was given through the University Research Ethics Committee at the University of East Anglia. As I am a member of staff, the proposal was scrutinised by colleagues from another School of study. Research governance approval was also sought and received from the local authority who employs the social workers, and the local NHS organisation who employs the health visitors.

4.11 Methodological issues

As discussed earlier in the thesis, the main epistemological assumption taken in the research is a social constructionist one (Hall et al., 2001, Gergen, 2008). Weinberg (2014) discusses the turn to language in social work and the value of examining the construction of ethical identities within social workers (p.86). Although I came to her work late in my writing of this thesis, Weinberg's account of the construction of ethical identities within variable contexts fits well with my perspective and the data I have collected here. The position I have taken draws on a number of different emerging traditions within the broader framework of discourse analysis, including critical discourse analysis (Potter, 1996, Wetherell et al., 2001), positioning theory (Harre and Langenhove, 1998, Harre and Moghaddam, 2003) and ethnomethodology (Hall et al., 2006, Hall et al., 2010).

Within discursive psychology there is some debate about the value of interviews as suitable subjects for discourse analysis (Potter and Hepburn, 2003, Hall and Slembrouck, 2011). Hall and Slembrouck take issue with naïve

interpretations of interview material questioning its value as a constructed event in making sense of language practices. They, along with Potter, identify naturally occurring speech as a more methodologically sound approach to making sense of ‘language practices’ (Hall et al., 2010). Despite these objections, analysis still offers a way of making sense
of social realities and interviews, whilst being wary of the artifice involved, offer rich areas of analysis.

4.12 The interview process

The interviews all took place at agency offices for the convenience of the participants. I kept field notes of all of the interviews outlining my feelings and the things I noticed about the venues and the participants. I was struck by the variation in the office spaces – some had their own rooms and desks whilst some practitioners shared spaces with other workers. At all of the addresses there was some element of co-location of teams, although none included mixed health and social care teams.

In one of the interviews the health visitor locked her door so that no one could interrupt. At one point during the interview we all stopped to talking as someone knocked on the door. We waited until they had left before we resumed.

The interviews were loosely structured. I informed all participants about the subject of the study and asked questions about the cases that they had worked on together. The lengths of the interview varied from 50 minutes to

120 minutes. Each was recorded and transcribed for analysis. All participants were invited to contact me if they wanted further clarification about the research or wished to withdraw their permission for me to use their data. None of the participants contacted me subsequently.

4.13 Analysis

The analysis was completed through listening to the recordings a number of times, reading through the transcripts and making notes that I then worked up into themes relevant to the research question. A distinctive element of discourse analysis is the reliance on the context and coherence in the textual data (Kvale and Brinkmann, 2009). In establishing the analysis, an iterative approach to the literature is indicated as the discourses that are established and examined within the analysis can be located in wider discourses (Seale and Silverman, 1997, Wetherell et al., 2001). Part of the analysis involved a comparison with the existing and emerging literature therefore.

There are a range of different approaches to discourse analysis (DA) and some are more formalised than others. My interest was primarily in looking at the language interactions between the health visitors and social workers in the interviews. The work of Goffman on interaction rituals (1955) provided a useful theoretical framework for this. There is a debate within the theoretical field about the cross over between more formalised approaches for example critical discourse analysis, (Potter 1996) and less formal approaches, for example those used in ethnographies. Dingwall's health visitor study (1973)

provides a good example of an ethnographic approach that focuses on the construction of institutional meanings through talk and ritual (Smith 2006).

Ethnomethodological Indifference and Institutional Ethnography

Garfinkel (1967) challenged the idea that more formalised approaches with pre-determined measures are always the most appropriate when engaging with complex context specific subjects. De Montigny (2016) argues that Garfinkel's presentation of ethnomethodological indifference (EM) creates implicit obstacles for social work. He suggests that EM can be seen, at first sight, as a rejection of using ethnomethodology as a tool for either exploring theory or improving practice outcomes. He does, however, go on to suggest that the situated, contextual knowledge (haecceities) identified in Garfinkel's argument can be bridged to practical action through institutional ethnography. Miller (1994) and Smith (2006) explore these issues in later works and make suggestions about how institutional ethnography can be applied within research in the professions. Miller (1994) argues that:

> 'Social realities are produced (or accomplished) by seeing and communicating from standpoints (or gazes) that are simultaneously ways of understanding and being in social worlds'
> (Miller, 1994; p.281)

In this study I wanted to understand better the ways in which ethical relationships were established and a less formalised approach felt more appropriate for eliciting a rich understanding of working practices.

Miller (2006) argues that approaches to ethnography are ideological. For example if you approach institutional relationships with pre-determined categories of analysis you risk marginalising or eliding minority perspectives. Consequently, you might not pay attention to constructs formed from ideas or experiences that emerge from the participants. In addition, some types of stories will be excluded. For example, researchers may focus on pre formed categories such as the use of high status words. However they may then not attend to what else is going on. More informal and situated approaches, such as Miller suggests, would allow categories to emerge from the data rather than being imposed in a pre-determined way, as in approaches such as content analysis.

Summary

The methodological framework for the studies is essentially a discursive one. Within the analysis which follows in the next chapters, language practices are the object of the analysis. Although I have taken an eclectic approach to the analysis, there is a coherent underpinning to the methodological stance that has been adopted. The works of Goffman (interaction ritual), Wetherell, (interpretive repertoires) and Miller, Smith and Dingwall (institutional ethnography) provides theoretical and practical frameworks for the approach that I took. Although the primary data collection was through an interviewing approach, by taking the approach outlined here, I was able to attend to the institutional context of the participants' talk, as well as the ways in which they used language to work-up their identities and subject positions. De Vault and McCoy (2006) set out some of the limitations and strengths of interviewing

(which they prefer to call ‘talking to people’) and emphasise the role of reflexivity in the interview itself. Although institutional ethnography as a framework was not present in my original ideas about the research presented here, I can see that it provides a helpful and apposite set of ideas that fit well with what I was trying to achieve.

Chapter 5

Case Study analysis

Introduction

Professionals working with children and families in England are often required to make difficult decisions about the welfare of children. These decisions are often further complicated by conflicting legal, ethical and policy issues (Dickens, 2013). Moreover, professionals are required to account for their decision-making to a range of interested and often critical parties. This small qualitative study explored the accounts of social workers responding to a short case study. This thesis looks at the ways in which the workers accounted for the ethical basis for their response to the case, and how they engaged with multiple dilemmas generated by the case study. I use a discursive approach to the analysis and consider how the language practices of social workers connect the micro-practice of casework with the wider discourses of child protection in England.

Within this study, social workers were asked to respond to a fictional case study using an online ethical decision-making tool called The Values Exchange. The tool allowed participants to respond to the case study in a staged and structured way. Firstly, respondents were asked to decide whether or not to agree to a proposition. They were then invited to respond to a series of questions that encouraged them to identify the values that prompted their decision. Participants were also invited to leave free text responses, including an opportunity to propose a different course of action within the case.

5.1 The Case Study

The case study was written as a short and plausible case study designed to present the participants with a number of dilemmas common within social work. The case study was developed from a complex case involving a family that I worked with as a social worker in a child protection setting. Details were modified to protect the confidentiality of the service users and professionals involved. I deliberately minimised biographical elements in order to achieve this. The case concerned a heterosexual couple with a number of challenges to their parenting, including learning difficulties, mental health issues and poverty. They are socially isolated and estranged from their family networks, through the consequences of abuse and loss. In addition to this they recently lost the care of their two young children following the intervention of statutory services. In the case study, the mother is pregnant and the proposal states that there should be a plan put in place to remove the child shortly after birth. See Appendix for a copy of the case study.

The Values Exchange is described in more depth in Chapter 4. To summarise, the online tool allows respondents to indicate ethical preferences in relation to the case study. They must indicate whether they agree with the proposition to remove the child at birth. Subsidiary questions ask them which particular values they prioritise in their decision-making. They can also leave free text responses to elaborate on their thinking.

5.2 Description of responses

There were fourteen respondents to the case study (five men and nine women), five of whom were health visitors and nine of whom were social workers. The responses were distributed across the two professions as follows:

Agree with proposition N= 9 (4 Health Visitors and 5 social Workers)
Disagree with proposition N= 5 (1 Health Visitor and 4 Social Workers).
Five of the participants gave free text reasons for their decision to agree or disagree with the proposition.

Reasons given:

Agree:

1) *The safety of the child is paramount, but it is important to balance these with the views of the parents and extended family.*
2) *I believe the best decision considering the previous history is for the baby to be removed as soon as born.*

Disagree:

1) *Unhappy with the current amount of information to fully agree to the proposal at this time.*
2) *That although the past has to inform current decisions, there is a need to give the parents the opportunity, if they wish for it, to parent their child. Part of the assessment around this will be what support needs*

they have and whether any changes that they need to make etc. can be done within the child's timescale.

3) *feel that while the baby has a right to be kept safe- it also has the right to be brought up within its family if possible and his/her parents have the right to be supported to carry out their parenting role and do the best they can. Of course if further assessment following this support still suggests they are unable to care adequately for the child then this would need to be reconsidered. While on one hand the parents' past performance in caring for their children needs to be considered so that risks are managed appropriately on the other given that the mother has a learning disability it may be that she is more capable now than when she was younger.*

These responses illustrate themes developed further in the analysis section below.

5.3 Further Free Text Analysis

The following are two extracts from one of the participant's responses to the case study and the proposal. Participants were asked to either agree or disagree with the proposal that the unborn child be removed soon after birth. They were then guided through a series of questions about the values that they thought were most important in their decision-making. At a number of points, they were also invited to offer free text responses that enabled them to clarify their position. The extract below is from a participant who self – identifies as a social worker and who disagreed with the proposal. In this section of text, the participant is outlining their reasons for disagreeing:

SW3

Unhappy with the current amount of information to fully agree to the proposal at this time.

The case study and the proposal pose a difficult but not uncommon ethical dilemma for participants, where the rights and needs of a child are potentially set against the rights and needs of parents. The formulation of the fictitious case is intended to elicit discussion that reflects the complexities of practice decisions. There is clearly no 'right' answer to the proposal and the response here reflects this. The surface meaning of this excerpt functions as a measured and cautious response to the case study. The phraseology in the first section signals a willingness to remain in a state of uncertainty about what is going on in this family, but also a commitment to making a more definitive judgment in the future.

Taylor and White (2000) refer to the range of rhetorical devices used by professionals to 'work up' their identity in both talk and text. Professional identity is something that needs to be 'done' rather than assumed a priori (Taylor and White 2000, p. 137). In the example above the working up of professional identity is accomplished in a number of ways. The reference to the limited information and the reservation of judgment 'at this time' suggest definitional privilege (Smith 1978). The ability to define and diagnose are key features of professional power but can only be warranted by a clear

understanding of the ‘facts’ of a case. Professional judgment is subsequently required to make sense of the information available. However professional expertise is being established here through a suggestion that the information available within the case study is insufficient. Unhappiness with ‘the amount of information’ establishes a degree of discernment about what constitutes enough information to make such a momentous decision. It also establishes professional detachment within the decision-making process - the writer won’t be hurried into making a decision before all of the facts are in.

Detachment and a commitment to ‘mining’ for further information are markers of popular accounts of professionalism. The refusal to accept the presentation of the case study at face value might be seen as establishing a questioning approach to decision-making that echoes Laming’s suggestion of ‘respectful uncertainty’ in approaching accounts in child protection work (Laming 2003). However, in this instance the participant is responding to a case study rather than an account given by parents about their own circumstances. The participant is creating a position in relation to the primary account that questions the adequacy of the information provided as well as the decision-making implied in the proposal.

5.4 Alternative actions

In the second piece of free text, the participant suggests an alternative to the original proposal:

An assessment of the family would need to be completed before I would agree with the decision to remove the child. I would be looking to see evidence that changes had been made in the family and that they would be fully engaging with professionals and a good support network was in place to support them. I do believe that many families that have parents with a learning disability are still able to provide safe and loving care of children and have a basic human right to do this. They may need more assistance than others and that is what I feel my role would be to ensure that I cover all the areas of weakness and put support in place. (SW3)

The first part of the paragraph can be construed as a continuation of the working up or performance of professional identity (Dingwall 1977, Reynolds 2007). Alongside the establishment of a professional identity is the formation of a category entitlement (Potter 1996). Category entitlements function to reify the statements of stakeholders through 'the idea that certain categories of people in certain contexts are knowledgeable' (Potter 1996, p.133). In the text above the claim to entitlement is made through the reference to process or procedural knowledge as well as propositional knowledge (Eraut 1994). The use of the word 'assessment' near the beginning of the paragraph signals technical knowledge about how to develop a better understanding of the case. In social work the notion of assessment is ubiquitous. In this case it has particular resonance with both the government guidance (The Framework for Assessment of Children in Need and their Families, DOH 2000) and established competencies within the profession (CWDC 2007).

In this illustration, the call for assessment is stated in a passive voice - ‘an assessment of the family would need to be completed’ - but is paired with a first person statement – ‘before I would agree with the decision to remove the child’. One effect of this is to draw a distinction between the evidence gathering and the exercise of judgment in the decision-making process. The assessment is presented as neutral and distant from the individual practitioner. This has two implications. Firstly, it establishes the process as an institutional, technical enterprise whose mandate is outside of the professional discretion of the worker. White and Taylor (2000) refer to the way that professional terminology can be used to obscure the deliberation that leads to professional judgments. They cite the use of ‘neutral diagnostic language’ that leads to the presentation of accounts as ‘factual descriptions of the client or patient, their behaviour or circumstances’ (p. 158). This tends to elide the role of individual judgment in decision-making and closes off alternative ways of viewing the case.

Secondly, it operates as a form of ‘stake inoculation’ (Potter 1996), anticipating any accusation of bias in the subsequent formulation of the case. The use of ‘I’ in the second part of the statement re-establishes the category entitlement of the participant by reclaiming the centrality of professional judgment and authority - ‘I have to agree before action can be sanctioned’; or ‘I have to assess further before I can lend my authority to this decision’.

5.5 Claims to Values

The third sentence begins with a claim to beliefs and values about the nature of parenting and the capacity of parents with a learning disability to do so. The claim operates as a counterpoint to the more distant and technical connotations of ‘assessment’ and ‘evidence’ in the earlier part of the paragraph. The use of ‘believe’ both softens and humanises the decision-making process and positions the author as a person as well as a professional. In social work the relationship between values and evidence-based practice is clearly established within professional culture. For example, the Professional Capabilities Framework (PCF) reaffirms the idea that values have an equal place in the range of skills and qualities that are required for ‘capable’ social work (The College of Social Work 2012). In this case the participant could have continued with the professional trope initiated in the first two sentences – for example by foregrounding the evidence base for supporting parents with learning disabilities or by citing the professional responsibility to promote rights (as they do later in the sentence). The effect of citing belief in values is that it establishes a personal stake in, or commitment to, fair or humane outcomes for the parents in the case.

Traynor et al (2010a) looked at the role of intuition on nursing decisions. They noted that, in their study, nurses made a significant effort to avoid citing intuition as a basis for judgment. Traynor et al attributed this to the dominance of a scientific discourse within medicine, exemplified by a focus on evidence-based practice within nursing and medicine. In their study, the nurses struggled discursively with the need to present as being sound and scientific in

their judgments with the need to present their work as requiring decision-making skills gained through experience and ‘practice wisdom’.

Basing decision-making on belief, in the context of Traynor et al’s study, risks the possibility that the speaker could be positioned as irrational or biased in their approach to the case. As well as enacting a commitment to values, belief suggests faith in a process that is not open to scrutiny and might not be falsifiable. The belief might be founded on good evidence, but the evidence itself is not presented. Consequently, what is left is a personalised claim to expertise and knowledge.

5.6 Evidence from Fieldnotes

Despite recruiting forty local participants, and opening the tool online to a much wider, potentially international population for the Values Exchange exercise, I received only fourteen usable responses. There were seven responses that couldn’t be used as they didn’t self-identify as either social workers or health visitors, some identified as doctors for example, and were therefore excluded from my analysis.

Most of the forty potential recruits came from teaching events and visits to social work and health visiting teams locally. At one social work team meeting, there was, in principle, a high level of enthusiasm for completing the exercise. Much of this seemed to be motivated, however, by a desire to express frustration and dissatisfaction with professional relationships with health visitors. The Values exchange didn’t offer scope for exploring these issues and this may account in part for the lack of follow through. The Values

Exchange was an honest attempt to answer one of the research questions, but, on reflection, was not such a good fit with the broader aims of the research about interprofessional working.

Feedback from three out of the four health visitors who agreed to complete the tool whilst I was present, indicated some other challenges in using the Values Exchange. All struggled with the language used in the exercise. One participant said that she found the questions ‘strange’ and ‘unusual’. From my notes, I interpreted this to mean that questions about values sit outside the routine experience of the professionals in their work with families. For example discussions about practice might be framed with reference to fairness or placing the child at the centre of the support, health visitors were less likely to talk about social goods or rights in their day to day discourse.

Another of the four suggested that the language used in the questions might have influenced the way that she responded to the questions. These issues about language raise a further point about the how normative ways of talking about values reflect underlying beliefs and principles, and whether challenges to day to day ways of looking at practice may make professionals feel uncomfortable.

Summary

The responses to the case study, particularly free text responses, indicate that there were some clear differences between the health visitors and the social

workers in their responses to the decision to remove the child at point of birth. Although most of the health visitors said they would agree with the proposition, this was a very small sample and the findings could not be seen to be statistically significant. The slight shift towards removing the child might be reflective of the weight of current emphasis on the safety of children overriding the importance of giving the parents a chance to parent the child. The language used by both those supporting the proposal and those opposing it is influenced by the requirements within policy and guidance to both take decisive action (Parton 2014) and weigh up alternatives that might allow the family to remain intact (Dingwall et al 1995).

Some of these contradictions and tensions in practice will be explored further in the following chapters.

Chapter 6

Collaboration and professional relationships

Within the interviews, relationship building between the participants was frequently cited as a basis for the success of the working partnership. Since the recruitment for the interviews included success in working together as part of the criteria, it is unsurprising that participants should have identified reasons for this within the interviews themselves. There were a number of recurrent themes that were present in all or most of the interviews that will be explored below. Some themes that emerge from the data relate to the ways in which the participants construct and maintain the idea of good professional collaboration within their practice. A second issue is communication – how the participants maintained effective communication and how that is accounted for within the interviews. A third area of discussion here is the way in which the relationships between professionals are made and developed within the interview process itself.

6.1 Intimacy

In the following extract the health visitor and social worker had been talking about their general working relationship (rather than a specific case). The interchange occurs quite early in the interview:

Interviewer: You talked a couple of minutes ago HV about the personal bit so making time for the cup of tea and having a chat about general things first and so that sounds as though you feel that is quite an important part of the relationship*?*

HV: Yes I think so, I think it is about knowing the person like we would a family, knowing that person holistically and there is a… you don't… you only share what you want to share but I think it just helps that causal relationship building.

SW: Yes seeing somebody face to face regularly you build up a relationship with them you know. I know what (HV's) kids are called and you know I can ask her about them but also it breaks down those barriers too that when I have to ring up and talk about something difficult. I know who she is but you know I consider her a friend and it is like well we can talk about that face to… you know easily and those barriers are not already there whereas you know if I didn't know her and she got me on a bad day she might not think that I was such a nice person and might be reluctant to contact me in the future if she thought 'oh God SW is a bit of a bitch'.

HV: Yes it is really interesting when we had an evaluation of how this project was going, because I think in the [region] they thought it wasn't going to work but actually we are streets ahead, I don't know whether [SW} and I just formed that relationship really quickly.

The health visitor's remarks at the beginning of the section draws a link between the formation of relationships with service users and the development of the relationship between the two professionals. The use of the word 'holistically' (line 6) invokes professional language, more commonly associated with social workers (the Professional Capabilities Framework for example). Its use in social work practice suggests the embracing of totality and is used in opposition to the breaking down of practice into discrete competencies. Here, its use suggests a depth of relationship, or at least an openness to the idea that there is more going on than two professionals acting as the interface between two organisations. This is tempered a little by the health visitor foregrounding the choice about how much and what is shared (lines 6&7). The hesitancy here suggests that possibility of dissonance or of an 'ideological dilemma' (Billig, 1988). One reading of this could be that the health visitor is attempting to negotiate between two positions in her relationship with the social worker that could be contradictory. In health visiting and social work, professional relationships with families involve an asymmetrical flow of information sharing and a degree of professional distance. Here the health visitor is indicating the intimacy of knowing and being known in a more mutualistic, yet still boundaried ('you only share what you want to share') way.

6.2 Friendship

In her account, the social worker takes a less ambiguous approach and says that she sees the health visitor as her 'friend' (line 12). The clarification of the relationship in this way is in part made possible by the health visitor's more

tentative account earlier. Each of the episodes of speech in this section start with a ‘yes’, affirming the position adopted in the previous episode. In her account, the social worker starts by stating the conditions for relationship building as an almost inevitable consequence of regular and frequent contact (lines 8 and 9). Although the relationship is presented as a prerequisite for a ‘good’ working relationship, the relationship is also a product of the collaboration. Frost and Anning (2007) drawing on the work of Wenger (1998) looked at the ways in which communities of practice emerge in collaborative relationships. They argue, after Wenger, that joint practice generates new forms of knowledge through joint activity (Frost and Robinson, 2007). In this extract work practices create the occasion for the relationship, but the relationship of trust is presented as a product of intimacy. Having established the general conditions for the relationship, she then gives an example of information shared - knowing the health visitor’s children’s names. This presents a mechanism for achieving intimacy, arising not just from regularity of contact but also from sharing of details of family life. This knowledge also signifies a shifting of boundaries, moving the relationship from a purely professional one and presaging the use of the word friend a few lines later.

6.3 Boundaries

The use of the word ‘barriers’ in this sequence (lines 10 and 14) taps into a well-established discourse about the nature of professional relationships within child protection work (Atkinson et al., 2007, Reder and Duncan, 2003).

Public Inquiries make reference to the barriers between professionals that make information sharing and communication in general difficult (Laming, 2009, Stanley and Manthorpe, 2004). The use of the word here draws attention to the risks that the social worker might see in communicating with other professionals on a day-to-day basis. The participant highlights the possible penalty for her as a person if intimacy and trust are not established (lines 14-16) and suggests how she might be perceived by workers if she is 'having a bad day'. Barr (2005) suggests that an important element of collaboration is the way that individual workers appraise the 'other's' perception of them. Here the social worker indicates that close relationship with the health visitor guards against possible negative interpretations of her character. This in turn draws attention to the possibility that professionals make appraisals of each other's characters as a matter of course in their work (Bell and Allain, 2011). It also suggests that trust enables her to express a wider range of positions on her work than she might otherwise be willing to.

In this account, trust is facilitated by intimacy and this in turn allows for a more open and less anxiety laden process of communication. The meaning of trust in this context becomes a set of expectations or beliefs about how the 'other' will judge the actions of the self. The social worker's account implies that without this understanding the relationship might be rejected altogether:

SW: 'if I didn't know her and she got me on a bad day she might not think that I was such a nice person and might be reluctant to contact me in the future if she thought 'oh God SW is a bit of a bitch'. (Lines 14 – 16).

The laying out of the internal dialogue here demonstrates the social worker's interest in the views and judgments of the health visitor. This does the work of showing the co-participant that she is interested in her views, but also exposes her sense of vulnerability and uncertainty in the relationship. It also creates the sense of the participant as open and honest within the interview process by going beyond the 'front of house' (Goffman 1959) presentation of self and opening up the backstage elements of the self.

At the surface level the participants are jointly suggesting that the close personal relationship is directly related to success in their professional collaboration. This is consistent with some parts of the literature where informal networking (Brandon et al., 2005), and more fluid professional identities (Davies, 2003, Reynolds, 2007), are constructed around a shared area of work rather than strict occupational boundaries. It also challenges some areas of the literature where clear role demarcation and role clarity (Carpenter et al., 2003) and purposeful distinctions between professional identities (Anning, 2001, Bailey, 2012) are seen as important foundations for effective collaboration.

6.4 Shared experience 'knowing what it's like'

Part of establishing a trusting relationship is a sense of shared experience. Within the interviews this augments the value placed upon inter-subjectivity and empathy and serves as another way of accounting for the success of the

relationships. For some of the dyads joint visiting was a key part of the discussion in the interviews. In the extract below, however, the participants had not completed a joint visit and the basis for their sense of shared experience was based on their discussions about their work.

Interviewer: Okay, so does that depend on, does that depend on you being sure that HV is going to understand the context of what you are saying, so you feel it is okay about telling things because you think she will understand, yes?

SW: Well HV has worked with kids, she has been out and she has seen dirty homes, she has been out and done difficult visits under, you know, had experience in difficult things.

(HV: …having those difficult conversations isn't it?)

SW: Yes and sometimes it helps someone to have that intuitive knowledge about what it is like to go out and sit on someone's couch and you know be shouted and screamed at or go out and deal with a baby death or something like that and it is a supportive kind of relationship as well.

HV: And there have been some really, you have had some really horrible cases and it's, we have talked about you know, and it is not anything necessarily to do with the project but we have talked about them and I suppose it is like a bit of peer supervision really, unofficial isn't it?

SW: Yes, yes.

The absence of shared home visits represents a challenge to the authenticity of the notion of 'shared experience'. In this case the participants met regularly

in an office and talked about cases that their respective teams shared. In this account ‘intuitive’ knowledge takes the place of a physical shared encounter. The imagery of being on ‘someone’s couch’ can function as a metonymic representation of the home visit itself. In other interviews ‘being on the doorstep’ and ‘getting over the threshold’ are used in a similar way to evoke the processes of home visits and establish the context of the discussion. Here being on the couch is a prelude to verbal abuse – being ‘shouted and screamed at’ – and the worst kinds of vicarious loss that social workers can experience.

The reference to ‘a baby death or something like that’ can be read as an extreme case formulation (Pomerantz, 1986). Pomerantz presents extreme case formulations as a rhetorical device that lends authenticity and legitimacy to claims made by speakers (Pomerantz, 1986). In this instance the claim is unlikely, but not impossible. Child deaths on caseloads are relatively rare in the UK in recent times (Ferguson, 2011, Ferguson, 2004). However child deaths are an obvious concern for social workers and health professionals and their impact on individuals and the professions involved in child protection are well documented (Brandon et al., 2009, Jones, 2014). Here the ‘baby death’ invokes a sense of shared extremes that makes the experience inclusive to the participants and excludes those without this experience.

The health visitor goes on to underline the importance of the trusting relationship between the two by emphasising the quasi-therapeutic necessity of being able to talk about ‘horrible cases’. She goes on to acknowledge the

overstepping of professional boundaries in this work. The discussions about cases are referred to as a form of 'peer supervision'. This represents a partial repurposing of the meetings (lines 15-18). The use of the word 'unofficial' here suggests a level of autonomy about how the time on the meetings can be used. It might also be interpreted as transgressive in that the participants have chosen to align with each other, outside of their organisational boundaries.

6.5 Alignment and collaboration

In the following extract, from the third interview, the discussion focuses on how the two participants came to a common view about the service user. The case that they are discussing here involves a single mother with two young children.

Interviewer: Did you share the same view from quite early on into the case do you think?

HV: Yes, oh even before we even managed to, after the visit have a conversation, in the visit it was fairly obvious that we were both singing from the same hymn sheet and that our concerns were on the same page.

SW: But actually before that visit we were both quite open minded, your records weren't particularly worrying were they and ours weren't?

HV: No because mum had engaged with all routine health appointments and again we had only ever been in the lounge so it would, you know it had always appeared and mum had engaged with Health even for some outside issues so it wasn't even just the stuff we were contacting her for, she had touched base with us a few times for help with potty training and you know those kind of

things, so again on the face of it she looked like a mum that was loving, caring and –

SW: And engaging.

HV: Engaging.

SW: Yes she had struggled in the past but like you say –

HV: She had sought help!

SW: Yes she had asked for help so I think it was during the visit the misgivings started to become more apparent.

HV: And she slipped didn't she, her parenting slipped and when the questions were asked you could see her temper a little bit more and you could certainly see the way the little girl was responding to the tension in the room.

SW: Yes that is very true actually, and the way the little boy was as well.

HV: Yes very protective over mum wasn't he?

SW: Yes and, yes it was quite apparent actually that he had an issue with his sister as well and they were both very negative about her and you know the little –

HV: I mean he even lashed out at her quite, you know, I mean I know siblings, siblings lash out at each other but I mean this little girl did nothing the whole time I was there, was quite submissive wasn't she and you know when this little boy got, you know for no apparent reason, I can't even remember that he was provoked by her in any way, you know quite viciously.

SW: And mum did nothing until I said that you know 'I don't think that is okay' and kind of said to the little boy 'do you think you should say sorry to your sister?' at which point mum kind of gave lip service to you know, I don't think

she said very much and she moved on very quickly but it became more and more apparent didn't it that she was very negative particularly to the little girl.

6.6 Alignment

The section starts with a question to the participants about what point in the process of assessing the case they came to an agreement about what was going on. Making an assessment requires professionals to adopt an impartial and objective stance in relation to the family. This is both an ethical obligation (i.e. fairness) and a requirement for effective practice. Premature judgments in child protection are difficult to change (Brandon et al., 2009) with a danger that further investigation will be hampered by confirmation bias (Munro, 1999) and other errors of reasoning. Studies of Serious Case Reviews have also identified the risk of professionals being reluctant to provide professional challenge in some cases (Brandon et al., 2005,Brandon et al., 2009).

The alignment (DuBois, 2007) within the interviews is achieved, in Du Bois's terms, through the joint appraisal and evaluation of the 'object'. Du Bois defines the stance triangle in the following way:

> 'Stance is a public act by a social actor, achieved dialogically through overt communicative means of simultaneously evaluating objects, positioning subjects (self and others) and aligning with other subjects…'
> (Du Bois, 2007; p.163)

Within the interview process alignment is primarily achieved through evaluation of the case. To some degree this process is an obvious artefact of the interview process itself. As the interviewer I was asking both professionals

to evaluate their working relationship through the lens of joint casework and had recruited workers who had specifically worked well together. However, in the section above, the participants work hard to evaluate the parent and child relationship in overlapping ways.

The outcome is a moral subject position for both the professionals and the parent in the extract. The implication that the mother is ‘playing lip service’ to correcting the little boy over his treatment of his sister places her outside of the range of agreed moral behaviours in the narrative. The case has been jointly set up by the social worker and the health visitor to demonstrate the challenges of establishing honest engagement from parents where there are concerns about the care of children. The notion of disguised compliance (Reder et al., 1993) applies here – meaningful parental engagement cannot be taken at face value. The participants here are working to establish themselves as astute assessors, not to have the wool pulled over the eyes by potentially abusive parents.

Summary

In establishing their relationship within the interview process, the participants are presented with a number of ideological dilemmas (Billig 1987). The framing of the interview process requires them to perform a positive and harmonious relationship. There is also an imperative to establish that they are able to work well together to assess and identify potential abuse, whilst at the same time establishing relationships of warmth and trust with parents/carers and children. They must also be mindful of the potential for both bias and

perceptions of collusion - the absence of ‘professional challenge’ in their working relationship (Brandon et al, 2008).

The dilemmas and contradictions that are demonstrated here can be seen as being located in the contradictions and challenges that emerge form policy and guidance and as enacted in practice. In the next chapter I will look at how some of those contradictions are expressed in the presentation of relationships with service users.

Chapter 7

7.1 Relationships with service users

The need to engage with service users and to build relationships with them is prominent in the literature of health and social care. In social work the casework tradition that was the predominant model of practice in the 1950s and 60s emphasised the need to establish therapeutic alliances with service users (Stevenson, 1998). Other models for working with service users have emerged to compete with this one in subsequent decades, but the need to form some type of relationship with service users, within a case work or case management model, is a persistent theme (Howe, 2014). Currently there is a resurgent interest in the idea of relationship-based practice (Trevithick 2003, Ruch 2005, Hennessey 2011, Ruch et al 2011). Two models of practice are offered: psychodynamic and person-centred (Murphy et al 2013). The first aligns well with the casework tradition within social work, and stems from the idea of transformation through relationships. The second emerged from the work of Carl Rogers (1951) and the idea of non-directive person centred practice. Within the literature there are several rationales offered for the adoption of this approach, outlined in summary below.

i) Humanising practice. In social work several writers have emphasised the potentially dehumanising and alienating influence of managerial or technical-rational approaches to working with families (Eadie and Lymbery, 2007). The roots of this anxiety stem in part from an historical concern with need for social work to be mindful of the dangers of both structural and contextual forms of oppression in relationship with service users. These might be aligned to

ethnicity, economic class, gender sexuality, age or ability, or some combination of these. More recently these concerns have crystalized around the possibility of distant and unfeeling bureaucratic institutions oppressing families (and in particular parents) as a response to societal concerns about child protection. It is interesting how these concerns echo the work of people like Bauman (1993) and Arendt (1964) who first voiced these kinds of worry in relation to the abandonment of moral agency in the Third Reich. Relationship based practice is presented as a way of rehumanising the interaction between parents and workers as it suggests that workers are present themselves within the practice rather than only representing the authority of the institution. This resonates strongly with the work of Bauman and Arendt.

ii) Effectiveness. The efficacy of this approach is also suggested within the literature. Psychodynamic models emphasise the learning and growth provided within the therapeutic relationship (Hennessey, 2011; Ruch, 2011). In health visiting this is less explicit but models like the Solihull Approach talk about the containing role that the professional plays in the relationship with the parent, helping her/him by processing and giving back anxieties in a digestible form. These approaches offer a form of empowerment to the service user through the relationship. In a children and family's context, this growth offers direct and indirect benefits to the child/children. Less anxious and more insightful parents are likely to be more tolerant and sensitive parents, one important dimension of effective caregiving (Crittenden, 2008). Person centred approaches emphasise personal growth through the facilitated exploration of self. Empowerment of the parent again has a (hoped for) impact upon the

wellbeing of the child, as the parent may feel more effective and confident and able to manage the parenting task more effectively. The other dimension to efficacy is the extent to which the presence of the non-judgmental professional within the relationship gives rise to trust and openness. The quality of trust might encourage the parent to share information about themselves and their families that allows the professional to help them more effectively. It might also allow the professional to better understand the risks that the child might be exposed to, and in this way open the parent to jeopardy.

iii) Ethical coherence. Some writers argue for relationship-based approaches from an ethical standpoint. This rationale overlaps with the other two but has some distinctive features. Some authors for example Smale and Touson argue that an exchange model - where the professional and the service user offer information to each other based on their areas of expertise – is an effective defence against oppressive forms of practice. Houston (Houston, 2009) applies a synthesis of Hambermassian approaches to communicative reason and recognition theory (Honneth, 2001) to argue that asymmetry in the distribution of power can be addressed through mutualistic and inclusive approaches to relationships. Ruch (2005) and Hennessey (2011) both argue that the presence of the self in relationship-based practice brings an authenticity to the encounter with the service user. As with Bauman and Arendt there is an implication that the presence of the self as moral agent is a necessary precursor - if not a determinant - of moral action. Qualities such as empathy and compassion - necessary components of relationship based approaches - making distant and detached practice less likely. For Bauman,

and others, the sense of personal engagement with practice is the foundation of ethical relations (Bauman,1993)

7.2 Relationship based practice in the interviews

In the interview discussion that follows, the health visitor and social worker had been working together for a number of years and had co-worked a number of child protection and child in need cases together. Both had been qualified for at least five years and both had experience of working with vulnerable children prior to this. At the time of the interview the social worker was a senior practitioner in a duty team, responding to child protection and children in need referrals. The health visitor worked in a team that took in a very large number of families spread across a number of small towns in a wide geographical area. The interview took place in a meeting room attached to the health visitor's office base on the edge of a small rural town.

This discussion happened almost an hour in to the interview (which lasted approximately one hour and forty minutes). The extract that follows was a discussion about gaining access to families where there might be concerns about the welfare of children. This section follows on from an earlier discussion about the need to be honest with families and a rejection of 'fluffy' professionals who avoid directness with service users.

In this section the participants have been describing the risks to their safety and to the safety of service users when making home visits. They contrast their practice with that of police officers who might take a more direct and

controlling approach when visiting people where there might be a greater risk of violence. The health visitor and the social worker go on to explain how they manage situations where they might encounter reluctance or aggression from families:

***HV**: In those situations sometimes you have to do an element of collusion to be able to get in to do that assessment, and they are the ones where sometimes you are not honest in the beginning, you are constantly assessing the risk while you are there and you pick your battles don't you?*

***SW**: And then you can be honest…*

***SW**: But I think you say about having to say certain things to get into a household and you know in Social Work particularly if you are trying to get a parent to willingly agree to put their child in care because you have not got a Court Order yet or the Police aren't willing to protect, Social Workers, I am a very blunt and to the point person particularly in my practice HV will tell you but it is uncomfortable every time that you have to almost, it feels to me like manipulation, manipulate the circumstances to keep yourself safe, to keep the child safe, to keep one of the parents safe and I always try and be blunt and honest as soon as I possibly can be in a safe way, if I am not going to be able to be completely up front at the beginning and I have learnt to just say to parents 'I can't always tell you everything I just can't but I will tell you what I can, when I can' and that makes me feel a little bit better and they feel better because then they know that you are going to keep things from them sometimes so they don't feel quite so cheated by that and they know that if*

you can be blunt you know I find the blunter the better really, they hate you for about five minutes and then they are pleased that you have been honest so it then generally works better but it is uncomfortable to, the, where I was held, I mean it sounds very dramatic, held hostage but they refused to let me leave and they ran to stop me getting out of the door and they were very, very angry and threatening to harm me and I feel terrible because I just let them say whatever they wanted to say and I just was very calm and encouraged them to say whatever they wanted to say until they had calmed down and for me to get out and that still doesn't feel very, I would still like to go back and tell them exactly what my thoughts are about what they were saying so that they are really clear but ultimately I guess it would have been worse if their house had been raided by the Police and what have you so you know it is difficult isn't it, I hate not being fully upfront at all times.

***HV**: It is difficult but honesty is best where you can, I find being honest –*

***SW**: And just be honest when you can't.*

***HV**: Yes and you know when we have to follow up Police Reports of either domestic abuse in families or you know or there has been an altercation between parents and the children have been present you know they know why, as soon as I knock on the door I say 'do you know why I am here?' You know.*

***SW**: Yes they are not idiots, you don't always have to spell it out.*

***HV**: And they are like 'because of the Police' 'Yes shall we have a little chat about it?' Whereas I know some of my colleagues they won't answer the door or they will open the door and give them a few explicits and say it is nothing to do with you and slam the door in their face whereas I do lots of negotiation on*

the doorstep sometimes before I am let in and I think again it is about them just seeing that you are being human about it and you are not making judgments straightaway. You want to hear their side of the story because I often say 'I only know what the Police report has told me and that is what the Policeman has perceived it to be, maybe there is a bigger picture that I am not seeing'.

***SW**: I often find myself saying something very similar 'look I am here because I want to know your perspective, I don't want to know what everyone else thinks, I want to know what you think and I want your story first that is why I have come to see you' and that often helps calm them down a bit so they are open –*

***HV**: And then will kind of quite happily let you in and tell you about the argument, dispute with the neighbour and what is going on and –*

***SW:** And how it awful it is and then at the end of it then you have to say 'Oh I am really concerned!' And then that is awful!*

***HV:** Can I come back again? Can I come back?*

Interviewer: Why is that bit awful SW?

***SW:** I feel like I have cheated them, people love to tell me their whole life story and then –*

***HV**: And then you feel like you have set them up.*

***SW:** Well absolutely and I did that to the family that we started talking about today, do you remember how cross she was with me because she told me everything and then of course it is all in my report for Conference and in black and white, it is really hard for parents to take.*

HV: *But that is always the art of what we do [SW: and that feels slightly underhand}, you almost have to, it is a little bit of almost have to befriend people to get them –*

SW: *Well to certainly get them talking and opening up.*

HV*: To get them to give you the information and like you say it is sometimes really [SW: they really hate you] hard when you then have to turn round and say 'well I am actually really concerned by what you have told me today' because they look at you almost as if to say 'but you asked me to tell you' –*

SW*: And a classic thing in Conference or in Court 'well I never said that' and you go to your notes 'well you said this this and this on this day at this time' and you can see their anger 'but I said that to you I didn't say that to you as a Social Worker –*

HV: *No I told you as a visiting person to my home.*

SW: *Yes even though you have been really and I find it doesn't matter how blunt or up front I am with people and how clear I am about my role and –*

HV*: They don't hear it.*

SW: *Yes they don't until they see it in black and white or hear it said in a formal meeting and then they feel completely betrayed. I struggle with that even though that makes me quite good at what I do, I struggle with that.*

7.3 Engaging in the relationship

Crossing the threshold of the home and physically entering the family space are important elements of a successful assessment. From the enquiry into the death of Maria Colwell (Reder et al, 1993) to the enquiry into the death of Victoria Climbie (Laming, 2003) the failure to properly engage with and

interpret the home, and, more importantly, see the child have been cited as central failings in protecting children. Ferguson (2009) and Helm (2011) both address the challenges of accomplishing this whilst simultaneously relating to parents and focusing on the child.

In the previous extract the health visitor describes a need to ‘collude’ (line 1) with a parent in order to ‘get in to do that assessment’ (line 2). Later in the extract this shifts into ‘negotiation’ (line 42). These tactics are associated with success, and contrasted with the efforts of other colleagues who are faced with closed doors or expletives and slammed doors (line 41). These tactical descriptions could be framed as ‘engagement’ - the techniques required to begin a relationship - rather than ‘relationship building’, which implies a deeper and more complex set of relations. Within the context that the health visitor and social worker are describing, the engagement processes that are accounted for here might be constitutive of the whole relationship. In some circumstances there might be only one visit to the home and one engagement with the parent and child. If this is the case it makes sense to view the substantive part of the relationship as occurring within this limited frame of engagement.

7.4 Honesty

Honesty is presented as an important quality within this excerpt. The discussion about ‘honesty’ is recurrent but framed in slightly different ways. In some instances, the meaning is ‘directness’, associating an unadorned statement of professional view with effectiveness in communication and

winning over the parents/clients. This meaning is reinforced by the use of contrast rhetoric (Smith, 1978). A distinction is drawn between the strong and direct approach of the workers in the interview and the ‘fluffy’ and indirect approach of other social workers and health visitors, where fluffy is categorised as not honest.

The second dimension of honesty encompasses the workers’ appraisal of their relationship with the parents of children that they are working with. In this account the need to withhold information or intentions is highlighted. The health visitor expresses regret at what she characterises as a necessary act of bad faith in encouraging the parent to share information that she will later use to evidence their failings as a parent. The anxieties expressed by the health visitor about this echo the ambiguities within the health-visiting role identified by (Peckover, 2002, 2011). In her work Peckover illuminates a tension between ‘befriending’ and ‘policing’ the role of mother in health visiting work. She locates this in the historical legacy of health visiting, with health visitors helping families through a combination of health promotion and advocacy as well as exerting pressure to conform to social norms. Similarly, Abbott and Wallace (1998) suggest that they act as both helpers to parents and as a source of surveillance of families on behalf of the state.

Taylor and White (2000) identify social workers’ disposition towards truth finding in cases as a source of moral ambiguity in their role. They suggest that if workers approach families as if they are detectives trying to uncover a truth, then other moral obligations claimed in the social work role, for example

empowerment and social justice, become subsumed by the need to uncover what lies beneath the performance of the family that they are confronted with. Cossar et al (2011, 2014) identified similar themes in the accounts of children and young people who were subject to child protection plans. They suggested that children resented being treated as repositories of information for social workers (and other professionals), particularly if they felt that they were being 'mined' for information about their families that would later be used in Court reports or Child Protection Conferences to cast their families in a negative light.

In the preceding extract, the social worker was discussing the value of being 'blunt' with parents, equating bluntness with 'honesty' or veracity. In the excerpt above the discussion focuses on the need to withhold or manage information in order to 'get-in' to the household. One way of managing this contradiction between values and practice is to 'be honest about not being honest' or being clear to the parents that some information is being withheld at the beginning of the relationship. As in the rest of the interview, here the statements by the two workers overlap and support each other. In the fourth line the health visitor explains that, in cases of domestic violence, the family will know why she is visiting: 'you know they know why, as soon as I knock on the door I say' do you know why I am here?''. The social worker speaks at the same time to emphasise this: '…, you don't always have to spell it out.' The health visitor continues the narrative and voices the parent and herself in an exchange on the doorstep (line 6). The phrasing of the interaction suggests a cooperative engagement between the two parties. However, the health

visitor's question encourages the parent to reveal information without the professional having to do the same. The health visitor spells out the alternative to this by contrasting her experience with that of colleagues in the next few lines. The inability to get past the doorstep and 'get in' to the family is a theme that runs through the interview. Here the health visitor emphasises the importance of negotiation in this process, accounting for her success in 'getting in', rather than having the door slammed 'in their face' (line 8).

The substance of the negotiation involves a presentation of the professional as both human and willing to suspend judgment about what has happened and is happening within the family. Rather than withholding information or opinions, this positions the professional as someone who is genuinely open to different perspectives on an event or situation. The ability to withhold or not rush to judgment prematurely is seen as a key one in safeguarding work (Munro, 1999, Brandon et al., 2009). Elsewhere in the interview both participants reference their willingness to remain open to other interpretations of cases or other professional perspectives. They also cite a willingness to question other accounts by colleagues both directly (through professional challenge) and indirectly (through checking facts or opinions for themselves). The specific language used 'bigger picture' for example, also echoes and reinforces terms used earlier in the interview to reinforce the image of the worker as one who is conscious of the need to hold judgments carefully.

The social worker's interjection (lines 17-20) again overlaps with and echoes the account by the health visitor:

SW: *I often find myself saying something very similar 'look I am here because I want to know your perspective, I don't want to know what everyone else thinks, I want to know what you think and I want your story first that is why I have come to see you' and that often helps calm them down a bit so they are open –*

HV*: And then will kind of quite happily let you in and tell you about the argument, dispute with the neighbour and what is going on and –*

SW*: And how it awful it is and then at the end of it then you have to say 'Oh I am really concerned!' And then that is awful!*

HV*: Can I come back again? Can I come back?*

In harmony with her colleague, she gives an example of what might be said, as well as a commentary on why she might say it, and what effect it might have on the service user. In this case it helps '*calm them down a bit so they are open*' (line 20-21). As well as getting into the physical space of the service user's home, this approach is effective in getting into the emotional space of the service user. The claim that '*I want your story first'* (line 19) is at odds with the process of receiving a referral and responding to it. The first story (all be it a partial one) must already have been told and heard or else that social worker would not be visiting the family. The social worker also suggests that '*I don't want to know what everyone else thinks*' (line 18) which is clearly contrary to the process of assessment that social workers follow, and is alluded to earlier in the interview. The effect of these statements is to award primacy to the account of the parents themselves. Rhetorically, this

establishes the speaker as someone who is willing to listen to the parents before coming to judgment, but also sees their account as being the critical one in establishing what happened.

The dialogue (following line 20) proceeds rapidly, with both participants interjecting into each other's accounts. The effect of this again is to convey the idea of two workers with very similar, if not identical, experiences and views. The main focus here is on the effect of successful engagement with the parent:

***SW**: 'I feel that I have cheated them, people love to tell me their whole life story and then-*
***HV:** And then you feel like you have set them up'*

The tone and focus of the second part of this excerpt (after the interviewer's question in line 26) is markedly different from the first section. Here both interviewees examine the consequences of the 'use of self' in the engagement process. Both express regret at what they describe as 'setting up' and 'befriending' people in order to find out more about the event or general situation of the family. The regret is paired with the consequences of disclosure by the parents and the physical evidence of that in reports, case notes or opinions shared in meetings. The health visitor describes the process as 'the art of what we do' (line 32) and in an undertone the social worker says 'and that feels slightly underhand'. The effect of this to partially undermine the

claim that this is part of the 'art' of professional practice and to reduce it to a tactic which is morally questionable or 'underhand'. By the end of this excerpt both practitioners have established that this is an approach to practice that they feel uncomfortable with. Later in the interview the health visitor makes a claim that the approach is justified by a superordinate responsibility to put the needs and welfare of the child first. The sense that the service user is being deceived is clear:

***SW**: 'I didn't say that to you as a social worker –*

HV: No I told you as a person visiting my home.' (Lines 40-41).

The service user is presented as 'taken in' despite warnings given to remind them that they are talking to a social worker or health visitor who has obligations beyond the immediate relationship with the parent.

The account here foregrounds ethical issues that remain unresolved within the discussion. The participants characterise the problem as an ethical dilemma in that they feel a requirement to engage with parents in the way that they describe in order to do a 'good job' but feel that they are letting the parents down in some way:

*'**SW:** I struggle with that even though it makes me good at what I do, I struggle with it'.*

This passage can be read as a ‘struggle’ to manage the emotional impact of the parents feeling ‘betrayed’. Doing the right thing might involve choosing between the anticipated negative effect on the parents and the well-being of the child. It could also be read as an expression of ethical or moral distress (Banks, 2006). In this case there is some expression of that in the social worker’s account of how parents don’t understand her warning to them about her obligations until after they have shared their views with her. Here the resource deficit lies in the limited means that the social worker has to impress her role upon the parents. However, the very success of the relationship-based approach involves the parent ‘forgetting’ that the social worker and health visitor have professional obligations towards the wellbeing of the child that might override their obligations towards her or him as a person.

Discussion

The presentation of relationships with parents in this extract generates some significant conflicts for the participants in the interview. Murphy et al, (2013) argue strongly that there is a fundamental incompatibility between both person centred, and psychodynamic models of relationship based practice and statutory social work. They suggest that the controlling role of professionals in these settings is fundamentally at odds with the requirement to put the interests of the person at the centre of practice activity (Murphy et al, 2013).

In the extract above the practitioners express regret at the formulation of the relationship with carers. The regret can be read in a variety of ways. It could be seen as an expression of ethical distress – the gap between moral

perception and moral action (Banks, 2006b). Both participants express some regret that they are unable to clarify their role sufficiently to give the parent fair warning about the consequences of sharing information with them. They emphasise their attempts at clarity, but there is, however, also an acknowledgment that they are making use of the forgetting of this aspect of their role in order to lower the guard of the service user. There is nonetheless a dissonance expressed between what is espoused as 'good' practice (honesty, alignment with the parent, wanting to hear their story) and the ways in which they find themselves practicing (a sense of being underhand and of betraying).

There is also an ethical reading of the contradictions that the professionals identify. Although neither participant makes explicit reference to any formal moral frameworks, there are several that could apply. The focus on 'honesty' in the earlier part of the section suggests a character value, or virtue, that ought to be held by professionals. Honesty is also presented as a key principle that should be upheld in relationships with service users. It is the breach of that principle that is cited by the social worker as the source of distress in this account. However, there is some ambivalence about whether or not there is truly a breach of honesty, as both the social worker and the health visitor suggest that attempts are made to be clear with the parents about their role and the consequences of being open with them. The sense of 'betrayal' that the social worker identifies is associated with the relationship being built rather than with what the professionals have said or not said.

The social worker uses the words ‘cheated’ and ‘betrayed’ to describe the feelings that she attributes to the parents:

SW*:’I feel like I have cheated them. People love to tell me their life story and then…*

SW: *‘…until they see it in black and white or hear it said in a formal meeting and then they feel completely betrayed.’*

The account here contrasts with the high valuation of directness and honesty earlier in the sequence. In both parts the social worker and the health visitor promote the idea of ‘types’ of worker - those that will be direct and ‘truthful’ and those that are ‘fluffy’ and, by implication, will not be direct in order to preserve the relationship with the service user. These types could be read as being close to the idea of ‘character’ that is promoted in virtue ethics (Banks and Gallagher, 2009; Oakley and Cocking, 2001). In virtue ethics the character of the individual and their moral standing, rather than the principles or outcomes of moral decision-making, are seen as key (Clark, 2006). In the contrast rhetoric used to distinguish the social worker from ‘other’ workers, honesty is presented as a virtue in of and for itself, rather than as a principle or as a utility for achieving a good outcome. Furthermore, the speakers identify themselves with the quality - they are ‘honest’ as opposed to ‘fluffy’.

Oakley and Cocking (2001) outline the conditions for virtuous action (p.9-25). Amongst these is the disposition or intention of the ‘virtuous agent’. They suggest that the goodness of an act (as opposed to its rightness) is, in part,

decided by the motivation of the agent (p.12). Honesty for the purpose of deceiving, or in order to hurt someone doesn't therefore constitute a virtuous act. In the extracts above both participants express concerns that their good intentions (allowing the parent to tell their story) are misinterpreted as a deception when carers come to realise the consequences of sharing information with the health visitor or social worker. However, there is also a suggestion that both workers have a prior understanding that parents or carers may misconstrue the relationship:

'but I said that to <u>you</u>, I didn't say that to you as a social worker'.

Svensson (2009) identifies the need that professionals involved with care and control work might struggle to acknowledge the ethical complexities of their roles. In her study workers used a variety of rhetorical devices to 'write out' the control aspects of their work (Svensson, 2009). Svensson theorises that the participants in her research did this because of the dissonance caused by association between 'control' and 'badness'. The need to construct good professional identities, in her view, requires a scripting out of characteristics that seem incompatible with the idea of their professional role being intrinsically good.

In the transcript discussed above, the professionals seem to acknowledge the grey areas or contradictions in their practice. They make justification for their actions in 'betraying' the parent by citing the best interests of the child. The making and breaking of the relationship with the parent is presented as a

consequence of the imperative to make the needs of the child paramount. In the account given here the use made of the relationship building skills is presented as foreseeable but not intended. In deontological terms the betrayal of the parent could be construed as a form of the doctrine of double effect, where the interests of the child are intended, and the injury to the parent is foreseen but not intended. In this account the distress expressed by the social worker and health visitor could be understood as moral loss (Williams,1981) or agent regret (Wolf,1982). In this formulation the instrumental use of relationship building skills are compatible with ethical conduct, albeit with an emotional cost to the parent and to the professionals.

Chapter 8

Discussion

Introduction

Professional identities emerge from a multiplicity of sources including the more rigid presentations of the profession that might be supported by codes of practice, job descriptions and the ideals of a profession that emerge from its membership and the literature about it. Alongside these come the ideas of self that are constructed in relationships with service users, carer and other professionals within communities of practice (Wenger, 2010). As Weinberg argues (2014) the identity of one professional can be seen as a fragmented multiplicity of selves rather than a singular form, just as the identity of the individual can be seen as distributed across a plurality of selves.

Within the preceding chapters I have attempted to document some of the ways in which health visitors and social workers present and negotiate different ethical challenges and ethical identities within a series of interviews. Here I will draw together the emerging themes from the thesis and suggest some tentative conclusions about the implications that this research might have for practice.

8.1 Professional identities, professional relationships and professional knowledge

Within the interview transcripts and the responses to the case study, both health visitors and social workers can be seen to be negotiating ideological dilemmas that relate closely to their sense of personal and professional identity. Howe (2014) suggests that social workers can be seen as operating along a set of binary conditions. Whilst these are not necessarily oppositional, they do present possible tensions and contradictions that need to be resolved by individual workers and the profession as a whole. For example, Howe refers to the experience of social workers as both professionals and bureaucrats (p.29) and describes how these apparently antagonistic positions can be at least reconciled and seen as complimentary rather than oppositional processes (p.40). He does so in part by invoking Lipsky's idea (1980) of the 'street level bureaucrat' who through their knowledge of the 'nuts and bolts of the job' (Howe, 2014 p.40) can then exercise creativity and discretion in their work.

A key component of professional identity is professional knowledge (Anning, 2001; Taylor and Thoburn, 2016). Within my study, professional knowledge was characterised by the participants as being a way of distinguishing different areas of expertise. Dingwall (1977a), as argued earlier in this thesis, points to the motivations that one professional group might have for either distinguishing themselves from, or assimilating themselves into, another group. Within the interview extracts presented here, the participants

foreground the ways in which the successful working relationships allowed them to complement each other's skills and knowledge. For example, in interview 1 the social worker and health visitor combine, rhetorically, to designate child nutrition and care as a specialised area of knowledge held by the health visitor. In interview 2 the participants designate the health visitor as the professional who has expertise in child development whilst the social worker is presented as the professional with knowledge and expertise of risk assessment. There is an acknowledgement that individual workers might hold overlapping levels of expertise - for example that some experienced health visitors might be capable of accomplished risk assessments.

The influence of professional knowledge on professional identity can be understood as having different functions. Anning (2001) examines the role of informal and formal professional knowledge and its impact on the formation of professional identities within a multi-disciplinary early years team. Drawing on the work of Eraut (1999) she explores the ways in which co-working leads to co-constructions of knowledge derived from practice (informal knowledge) (Anning 2001). This in turn leads to the formation of new professional identities. The findings echo some of the ideas of Davies (2003) and Reynolds (2007) in that more fluid forms of professional identity emerge from the shared constructions of work, negotiated by the professionals within their joint practice. The surrender of certain areas of professional expertise - or claims to professional knowledge - can be seen as part of the process of relationship building. It also resonates with Rose (2011) who found that 'collective preferences' (p.161) are achieved through individual professionals letting go of

some of the boundary markers for their profession. For Rose the establishment of successful working across professions is dependent on more than just ‘establishing and committing to joint goals and plans’ (2011; p.161) but requires a more profound extension of responsibility and sometimes the sacrifice of some exclusive claims to expertise.

Within the interviews in this study, the examples of child development and risk assessment as areas of expertise that are designated to one profession or another, might be seen as either a way of settling boundary disputes or ‘turf wars’ (Allen, 2001) without rancour or conflict. It could also be seen as a way of developing and cementing the professional relationship and might be the basis of a reciprocal process of establishing trust and mutual respect. In the first interview that was conducted, for example, there was a long discussion about the social worker holding a particular expertise in understanding parenting from the perspective of adults with learning disabilities. The health visitor was willing to cede an important aspect of her claim to professional expertise (parenting and childcare advice) and partially share this with the social worker who happened to have received some training in this area around the time that they worked on the case together. As Wenger (2010) suggests in a wider context, and Frost and Robinson (2007) in the more specific area of child protection work agree, this kind of negotiation over boundaries is an important part of the processes that operate within communities of practice.

The establishment of effective working relationships seems to require some abandonment of the distinction between professional and personal identities. In the second interview, for example, the participants highlight the importance of sharing elements of their non-professional lives in order to establish coherence and trust in their working relationships. It is important here to distinguish between the presentation of the relationship within the interview and the ways in which the professionals might actually build alliances in their day to day work. The performance of interprofessional roles, and the establishment of interaction rituals (Goffman, 2005) is as present within interviews as it is in any other context (Harre and Moghaddam, 2003). However, the co-construction of the working relationship within the interview gives clues to the ways in which alignment and close cooperation are established in other contexts too. Accepting the ubiquity of performance in the formation of identities does not bring in to question the veracity of the accounts given within the interview setting.

8.2 Ethical identities and Ethics work

The struggle to ‘do the right thing’(Munro, 2011) is evident within each of the interviews. Whilst the participants do not overtly draw upon obvious sources of ethical guidance, or moral frameworks (or indeed the codes of practice for their professions) there are clearly some implicit systems or repertoires for ethical thinking present within the talk. The absence of explicit moral frameworks echoes the findings of Banks and Williams (2005).

The implicit systems can be labelled as such because they have a detectable structure and coherence and can be linked conceptually with the varied and sometimes conflicting practice imperatives that practitioners are presented with in their work. In the third interview, for example, both professionals articulated the dilemmas associated with established authentic and effective working relationships with parents. The 'values talk' in all of the interviews reflected the contradictions that are present within policy and guidance as well as the conflicts and inconsistencies that emerge from the complexities of the context in which the professionals operate. For example, the need to build relationships based on trust whilst remaining 'respectfully uncertain' of what parents might be telling you as a professional was evident in the third interview. From a discursive perspective these contradictions can been seen as an inevitable consequence of the clashing or conflicting discourses that are available to practitioners (Wetherell et al., 2001). They also resemble the multiplicity of contradictions that exist within policy and guidance directed at practitioners (Dingwall et al., 1995; Dickens, 2013; Parton, 2014).

Wienberg (2014) adapts Billig's (1987) concept of ideological dilemmas and applies this to the ethical contradictions that practitioners face in accommodating oppositional ideas of 'self-care' (linked with Foucault's ideas of technologies of the self) and professional self-sacrifice for the good of service users. The latter is akin to the concept of supererogation (Beauchamp and Childress, 2009) or going beyond the boundary of ethical obligations in an individual's professional duties. Weinberg points out that where the boundaries of obligations are unclear, and where, indeed, there are implicit

imperatives to prioritise others over self to a high degree; in these circumstances social workers may find themselves in a double-bind.

8.4 Implications for Training and Practice in Child Protection Work

The complex picture of health visitors and social workers trying to navigate the ethical complexities of their work can be read in a number of ways. One interpretation is that workers respond to the situational factors by adopting an active and agentic approach to their practice. Banks' (2016) idea of 'ethics work' fits well with this interpretation. Banks suggests that conceptualising the ethical sense making and ethical action that professionals undertake in their activity as 'ethics work' helps to highlight both the micro and the macro influences on their decision-making – a 'relational dynamic between people and contexts' (Banks, 2016; p.36). Banks contrasts this with 'rule based managerialism' (p.35) and emphasises that the situated context is much wider than the local setting in which individuals are present. This research resonates with those ideas.

Training and Education

Interdisciplinary training in child protection work tends to focus on breaking down some of the static or fixed differences and misunderstandings between different professionals (Morrow et al., 2005; Bell and Allain, 2011), many of which might arise from lack of knowledge of different roles or through misapprehension or professional stereotyping (Dingwall, 1977a). The findings

from this research might complement this approach by encouraging the idea that training might also incorporate the idea of relationship building between professionals as being an important factor in developing strong interprofessional working. Other commentators have made points about the value of relationship building at formal and informal levels (Brandon et al., 2005; Taylor and Thoburn, 2016). In drawing attention to some of the rituals and practices that promote alignment as well as affiliation between professionals, this research helps to flesh out some of the processes that might underlie successful relationship building in this context.

Within professional education settings, the situated nature of ethical decision-making has, traditionally, been less visible (McBeath and Webb; 2002, Banks, 2009a). The resurgence - or emergence - of virtue ethics, care ethics and discursive ethics (Hugman, 2005a; Houston, 2003, 2009; Banks and Gallagher, 2009) as well as the development of interest in researching 'close to practice' (Broadhurst et al.; 2010, Helm, 2013) have offered different perspectives on how ethical practice might be understood. Although interprofessional ethics as a field is not well defined (Banks, 2010) this research suggests that uniprofessional assumptions about unique ethical perspectives and practices being held within professions need to be challenged.

Practice

Practice in both health visiting and social work is subject to rapid changes in the organisation and delivery of public services. Within this study I have suggested that not only are both identities and ethical positions co-constructed, but that wider policy and practice issues impact of the parameters of this process. Following Weinberg (2014), I would suggest that professionals are both enabled and constrained by these influences. This would mean that the range of plausible ethical identities are constrained by the contextual factors within the work.

One of the challenges of viewing ethical practice as emerging from specific contexts is that of consistency. Fluid and shifting ethical identities might accommodate the complex nature of ethical practice but create challenges for continuity of identity. It also creates hypothetical challenges to the idea of a reliable ethical framework that professionals can refer to in their decision-making, and to solid positions form which practitioners can argue for certain kinds of justice (Beckett and Maynard, 2013). In the first chapter of 'After Virtue' (MacIntyre, 2007) the author posits the idea of a world in which moral cohesion and comprehension have fragmented. Using the analogy of a world where science has been destroyed and inheritors try to piece together disparate fragments of knowledge, he suggests that something akin to this has occurred with moral thought in the post enlightenment age. Without endorsing Macintyre's view on this, the need to find cohesion and some element of consistency in practice is a key value in itself and needs to be attended to by both practitioners and commentators.

8.5 Limitations of Study and Future Research

This is a small scale study that relies on accounts of ethics in practice from practitioners in interviews, and through comments on an online decision-making tool. Although the study casts light on the ways in which professionals are able to account for their practice, the reflections of practitioners are removed from the ecology of decision-making in situ.

A second limitation is the absence of a service user (expert by experience) voice. The representation and construction of the service user is an important element of the analysis, but their presence is inferred and implied rather than realised through participation.

One direction for further research might be through an ethnographic study, observing and recording social workers and health visitors on home visits. This would be ethically complex but would enable the direct participation of service users and would allow for both joint and individual accounts of the decision-making processes. As Banks (2016) points out, different approaches to data collection and analysis tend to make different processes ‘visible’ (p.45). Ethnographic work would elicit different aspects of ethical practice and might in particular shed light on fluctuating elements of the power relationships between different professionals and between service users and professionals.

Conclusion

The ways in which professional identities are conceptualised are key to making sense of the issues of interprofessional ethics. If we view professional identity as a static 'solid' form it pushes us towards explanations for interprofessional conflicts that emphasise competence and knowledge. Whilst these conditions are important, overly focusing on the static identity pushes us away from examining the complex ways in which identities are constructed and performed within practice. In the latter case, making sense of these more fluid forms of ethical identity, through formal and informal examination of the micro-interactions that shape relationships in practice might allow us to better understand where unwanted professional conflicts emerge. If professionals have a better understanding of the dynamics of their working relationships, they might have a better chance of engaging purposefully with the problems that they encounter there. Whilst the role and relationships of social workers and health visitors is neither identical nor symmetrical, the work that they share in child protection generates common perspectives and ethical positions as well as oppositional and antagonistic ones.

At a policy level, it is not sufficient to assume that improved editions of Working Together will improve practice in the round. This research highlights that it is the ways in which people work together that are significant, and that there is no simple formula for getting this right. Current policy approaches such as joint governance, co-location, and common guidance can provide some clarity. But they don't necessarily deliver more just and effective outcomes for children or parents – as has been noted extensively in other

research. Providing environments in which workers can safely explore and determine the right interventions for families involves much more. I would urge that organisational culture must be addressed to encompass kindness, compassion and trust as essential working attributes. As Ruch (2007) suggests, organisations must contain rather than exacerbate anxieties about the work of their employees if they are to create environments within which safe practice can emerge and thrive.

Finding a reflective space is important for making sound ethical judgements. Relationships between professionals are important and need nurturing. Organisations need to give time and space to establish and support professionals to accomplish this and make this a workforce priority. At an individual level, practitioners need to take responsibility for reflection in collaboration with others. In this study, the degree to which all of the dyads achieved this varied, but it was still accomplished by all of them at some level. This often appeared to be in spite of, rather than because of, organisational arrangements.

Establishing good working relationships is a starting point, rather than an end in itself. Maintaining strong and effective relationships allowed some participants to provide space for doubt, disagreement and the temporary suspension of judgement. All of these questioning and reappraising characteristics aid good decision-making.

In professional education, we need to emphasise the emergent and interactional qualities of ethical decision-making to balance the existing more linear and individualised perspectives. This could be achieved by making sure that students are comfortable with incorporating every day, nuanced ethical insights into their thinking. This in turn would help them manage the vicissitudes of day to day decision making and make them more confident in dealing with uncertainty. From my experience as a social work educator I can see that opportunities to reflect on the values that are applied in social work practice are plentiful. Opportunities to expose and manage the influences that collaboration with other professionals, as well as organisational climates, have on decision making are rarer.

In my experience of social work education, there is a model of ethical thinking and action that focuses upon the autonomous, morally informed individual. I would contend that situated and interactional elements of ethical perception and decision-making are equally important and need greater space and recognition within professional curricula. Feminist and postmodern approaches to ethics foreground these issues well but seem to have limited purchase within qualifying training. To remedy this, I suggest that educators shift from using abstracted and idealised cases in discussions about values, and instead make use of real practice scenarios and case studies. This has been advocated by others (Banks 2008 for example) and is relevant to all professional groups working in child protection. I would also add that students and practitioners need to be conscious of and bring to supervision the ways in

which relationships with colleagues in other professions impinges on their ethical decision making.

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Appendix One: Reflexive Account

The introduction to the thesis identifies my personal investment in the areas of inter-professional working and ethics in professional life. In this appendix I explore the thoughts and feelings that I had during the fieldwork and analysis and the composition of the thesis.

Approaching the Literature

The policy guidance on working together seemed really important to me as the genesis of the Working Together documents arose through attempts to resolve inter-professional conflicts which had resulted in the death of a child. All of the major revisions of Working Together have been as a result of enquiries into child deaths, and all have, to some extent, focused on clarifying professional roles. What I was examining in particular was the instructions to social workers and health visitors within the documents, and whether or not there were areas of professional discretion and autonomy. I was also interested in the ways that the two groups were portrayed as professionals, and the implications for how they were expected to behave.

I was struck by the way that health visitors roles changed throughout the documents. For example, in some iterations of the document, health visitors are given a clear surveillance role in relation to families. In later versions they have a much more peripheral and tangential information providing role, less rounded than the more developmental role they had earlier on. Conversely,

there is less change in the social work role and although they are the key child protection professional, ironically, they are rarely referred to by their professional title social worker. Having studied the documents, I began to wonder if they merely highlighted the tensions in professional working rather than resolving them.

From the wider literature about inter-professional working and where the conflicts and positive working practices arose, it struck me that many of these processes involved identity work. Some of the literature addresses this directly in the form of discussions about identity needing to be performed in certain ritualistic ways. I had read the work of Goffman and his ideas about the performance of the self, and interaction rituals many years ago, but it was later in my analysis of the interviews that I really began to see the salience of his ideas to my research. Interestingly this had been prompted by listening to a podcast about Goffman and his work. In retrospect I could have used Goffman's work more in the thesis and intend to do so in publications stemming from my thesis.

When considering the history of ethics, I was surprised by the extent to which the notion of professional ethics has changed since the formation of social work and health visiting in the nineteenth century. Many of the normative expectations about professional ethics are relatively recent with most of the work on bioethics, for example, originating after the nineteen seventies. I noticed that there were quite close parallels in the origins of social work and health visiting – both emerging from nineteenth century concerns about family

welfare and anxieties about moral inadequacies in families. Looking back on this, I wonder if some of the worry about hygiene in particular transposed itself into a drive to regularise and cleanse poor and working class families, the great unwashed.

I was interested in the evidence of an ongoing struggle in both professions to identify themselves as ‘good’ over their histories. The defining characteristics of ‘good’ change over time, from helping families deal with the practical consequences of poverty, to rescuing children, to more modern notions of empowerment. Looking back, however, it seems to me that there has been a continuous drive to make families fit into a ‘middle class’ framework of family life and behaviour.

This crossing over of roles was a recurrent theme, and often seemed to exacerbate instances where there was conflict between the two professions. I noticed as well that in the contemporary era, there are more social work texts about values and ethics and very few specifically about health visiting. In part this is a result of health visiting being subsumed by bioethics in health which marginalises their role as a subset of community nursing. This struck me as odd, given the very specific ethical issues that health visiting throws up. Both professions are numerically small workforces, but I wonder whether the greater volume of commentary in social work is reflective of identity issues. Perhaps ideas of accountability for statutory roles are more obvious and prominent in social work than health visiting. This may in turn lead to the

requirement to reflect on ethics as part of a checking process, even though the ethical challenges in both professions are of a similar magnitude.

Thinking about the methodology and analysis

In thinking about the methodology chapter, I had a preoccupation when I was designing the study, and also the analysis, about the relative strengths and weaknesses of qualitative design. I had little interest in developing a thematic analysis of the interviews and categorising the interviews in that sort of way. Nevertheless, I was aware that thematic approaches are easier to validate in social work research than discursive methods.

I wanted to be careful not to be too critical of interpretative approaches to analysis in the way that some authors, such as Potter (1996) and Hall (2011) have been. Hall in particular describes thematic analysis as ‘naive realism’. I do, however, see some value in these kinds of interpretative approaches to research, for example in collecting the views and experiences of marginalised groups. Both authors mentioned above emphasise the contextualised and contingent elements of meaning within interviews. This kind of thinking fitted with my interest in exploring the linguistic and ritualistic elements of the interviews. This fitted with a long-term interest in language and its role in shaping social realities that goes back to an earlier time of my life when I studied philosophy of language and linguistics.

I was keen that the methodology involved me in a reflexive position in the interviews and in that sense the methods shifted slightly towards an

ethnography. I was aware that the interviews comprised interactions between both the participants and myself in a very particular event, and that it was this that was being analysed. At the same time I was conscious of the challenge of translating my conclusions into observations about the world outside the interview setting.

I often found conducting the interviews quite moving, particularly the dedication that the participants expressed towards their work and how much of themselves they put into their decision-making. They also mostly resisted distancing themselves from their work and relying on institutional and procedural language to justify their decisions. Reflecting on this now I can see that those displays of personal commitment represent ‘skin in the game’ (O’Neil, 2012) for practitioners. Perhaps they were prepared to reveal this to me because I too revealed an emotional investment in the event and the topic as an insider.

The interviews all took place at venues where the participants commonly worked. I was struck by the different feel to the centres where people worked and the odd rules and rituals I encountered. In one place, the health visiting office was adjacent to an open ward for adults. There was direct entry into the ward, and I had to pass through this to get to the office where the interview was to take place. Before the interview I was offered tea, but the tea room turned out to be locked and inaccessible. I was amused and puzzled by the contradictions in making the tea more secure than patient privacy. In another interview, the participant had to lock us in her room in order to avoid

interruptions. Whenever someone knocked on the door, we had to be silent and pretend not to be there until they went away. This conveyed a real sense that the worker was under siege from the demands placed upon her.

One of the key points from the interview analysis was the description of the ways in which participants managed their professional relationships with each other. I was surprised by how much detail participants were able to go into about the ways in which they built their relationships, and by how much of themselves they were prepared to disclose. Although it was a small sample, there was a range of experience amongst the participants. One dyad had only worked together once, for example, whilst another had been meeting weekly over a period of several years. There were quite similar tropes that arose during their discussions, and they accounted for their positive working relationships in quite similar ways. Some tropes drew on institutional language, for example putting the needs of the child first. Often, though, they talked about shared experiences and it struck me that there was often a performance of humanity within the interviews in a Goffmanesque way.

Concluding thoughts

In framing the discussion and the conclusion I was conscious that my role as interviewer mirrored the relationships that the participants built with service users. Whilst I was using my knowledge, skills and understanding to help build a relationship with interviewees, they were describing using similar attributes to establish relationships with service users. Some of the interviewees

expressed ethical qualms about the process, where what the service users revealed to them might expose families to judgement or sanction. Any conclusions that I drew about their practice would be subject to this same unease about whether I had seduced them into revealing weaknesses in their behaviour that might lead to criticism. Whilst my responsibilities are not equivalent to those that the interviewees hold towards children and families, this reflection did sensitise me to the ethical complexities and discomforts carried by the professionals in their work.

Appendix 2 – Participant information Sheet

Values and Ethics Research

Participant Information Sheet (Interviews)

Purpose of the research

I am interested in exploring the ways in which professionals involved in child protection and safeguarding work engage with ethical issues and dilemmas. This is the second part of the study and it involves interviewing a pair consisting of one health visitor and one social worker who have worked successfully together in a child safeguarding case.

The Interview

The interview will take approximately one and a half hours. It can take place at the University of East Anglia or at your workplace at a time and day that we agree upon – most likely within normal working hours during a normal working day for the participants. The interview will consist of a discussion, prompted by questions by me, about a case that both participants worked with. The questions will be about the ethical issues that the case raised and about how these issues were resolved. The interview will be digitally recorded and transcribed.

As your work involves safeguarding and child welfare, it may well be that some of the discussion will touch upon distressing issues, however no more so than those that you would encounter in your day to day work.

Confidentiality

The focus of the interview will be the ethical issues raised by the cases. Names and other identifying information about service users or carers should be avoided. If any identifying information is used by mistake, it will be edited out or anonymised in the transcripts.

In the writing up of the analysis, and for any published materials, your identity will be kept confidential. Any quotes that are used will be carefully screened to make sure that you cannot be identified. Your employer will not see any of the raw data from the interviews

Ethics Approval

This research is approved by the University of East Anglia's research ethics committee, by Norfolk County Council and through local NHS governance scheme.

Consent

You may withdraw your consent to the interview at any time before or during the interview. You may ask to stop the interview for a break, or for any other reason, at any time. Following the interview, you can ask to withdraw your data for a period up to and including two weeks afterwards. You do not need to give any reason for wanting to withdraw from the research, and you will not be asked for your reasons.

After the Interview

I will check with you and the other participant how you feel and whether there are any issues relating to the interview or the research that you wish to discuss. You can contact me by email or by phone after this if there is anything related to the research that you wish to talk through.

Safeguarding Issues/Poor Practice

If any issues that relate to the wellbeing of you, or any of the service users that you work with arise during the course of the research, it may be necessary for me to contact appropriate services. In the first instance I will refer any issues of concern to Christine Barnett (Health) or Paul Corina (Children's Services). If this need should arise, I will, if possible, discuss the issues with you before I take any further action.

Concerns

If you have any concerns or complaints about my conduct or the research you can contact my Head of School, Professor Gillian Schofield g.schofield@uea.ac.uk. Alternatively you can contact the chair of the School Ethics Committee, Beth Neil at e.neil@uea.ac.uk .

I consent to participate in this research project and to the use of my views in the research analysis.

Name:

Date:

Thank you for considering becoming a participant in this research

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Appendix 3 - Transcript of one interview

MIRANDA (HV) and HEATHER (SW) Interview 3 (all names are pseudonyms) Text in bold is Interviewer

Ok so we are recording now, first of all thank you very much again for agreeing to be part of the study today. Can I just start by asking you to tell me a little bit about you and a little bit about how long you have been practicing and how long you have been qualified and how long you might have been working in this particular area?

HEATHER: So I'm {name} I am a Senior Social Worker in …. I have been a qualified worker now for six years working the majority of the time in Safeguarding and most of that in front end Duty work but I have also spent a year working with Looked After Children. Prior to qualifying I also spent three or four years working with vulnerable children and adults as an Appropriate Adult with the Police. I was a Mentor to Leaving Care Children and I did a couple of years working as a Support Worker in a Mental Health Day Unit as well, so I guess I have been working in this field for about ten or eleven years now.

Okay thank you.

MIRANDA: {name} Health Visitor here in (Townson and Chapman). I have been Health Visiting probably for about six or seven years now, prior to that I was a Staff Nurse, Adult Staff Nurse working in Obs and Gynae. So a few transferable skills but most safeguarding came with the Health Visiting title.

Okay thank you, so could you start by just describing the background to the case that you both worked on and that you want to talk about today?

HEATHER: We have worked on a few but we are going to do the one on …?

MIRANDA: Yes, yes.

HEATHER: Yes fab, so crumbs that is a long time ago now, I have slept since then! So that was an urgent, was that an urgency?

MIRANDA: It was, it was a joint, initial joint visit wasn't it?

HEATHER: Yes and that was before the joint protocol came, way before the joint protocol came in but I wanted you to be there because we were concerned about the development of this little girl, well there were three children?

MIRANDA: There were two to start off with, the third one came along towards the end.

HEATHER: That's right and the girl particularly we were concerned about, her development whether she was where she should be, so we decided a joint visit would be the best way forward and she is a little girl who, with the stickers, that I have never forgiven MIRANDA for! Because she struggled to engage didn't she, she hid behind the sofa for a long time and then, and just wouldn't talk to me because I am so scary and MIRANDA had stickers. She came over to me and then saw MIRANDA's badge and stickers and that was it, straight on MIRANDA's lap and then you were the one who was actually able to engage the child weren't you? You got her talking, you got upstairs with her and –

MIRANDA: Yes, it was incredibly difficult she was a very, you know it was quite shocking to see a child of that age behaving in that manner, very fearful, very timid little creature but interestingly as soon as she obviously felt that I was a safe person and as soon as I showed her a little bit of attention, on my lap straightaway, very much wanted me to go upstairs, invited me upstairs which was, you know where we were wanting to try and get, mum was resisting, but you know quite happily wanted to show me her bedroom and yes engaged beautifully once, I mean I think the trouble there was the younger sibling at the time was so dominant and so aggressive in his behaviour that she almost was the –

HEATHER: And Mum was very dismissive of her wasn't she, she scapegoated for everything, mum really couldn't care less about her in that sense which was evidenced by what you found upstairs as well wasn't it, where every book was torn, her bedroom was a wreck wasn't it?

MIRANDA: Yes.

HEATHER: Although you would never have known from downstairs, downstairs was alright wasn't it?

MIRANDA: It was good enough wasn't it?

HEATHER: Exactly yes yes.

MIRANDA: Yes shocking.

HEATHER: Yes and she had a lot of unexplained bruises.

MIRANDA: Yes.

HEATHER: He was one at the time, she was three, he was blamed for most of those bruises but actually we weren't convinced so –

MIRANDA: No.

HEATHER: No, but the Police who came out after we had seen those bruises were quite difficult and not particularly keen to engage, they were very willing to believe mum's account, so I think actually it was our work that helped to progress the case and we got it to Conference with very genuine and worrying concerns, the Police were no help! So I mean our joint working just remains –

MIRANDA: And mum was very convincing wasn't she, I think –

HEATHER: She was plausible yes, yes.

MIRANDA: Yes she was very convincing and it was only when, you could ever really see what was going on when you were in the family home, when they were outside of the family home, all would appear actually like quite a loving family and quite, and yes it was alarming to go in there and see a child of that age behaving like that.

HEATHER: Exactly and seeing downstairs, the Police only saw the living room which was good enough, the adult areas were fine, it was the children's areas that were not acceptable and the Police never went to the bedroom they had no cause to, so yes I think if I had been a lone voice shouting in that case we probably wouldn't have been able to take it further and those children would have been at further risk.

Did you share the same view from quite early on into the case do you think?

MIRANDA: Yes, oh even before we even managed to, after the visit have a conversation, in the visit it was fairly obvious that we were both singing from the same hymn sheet and that our concerns were on the same page.

HEATHER: But actually before that visit we were both quite open minded, your records weren't particularly worrying were they and ours weren't?

MIRANDA: No because mum had engaged with all routine health appointments and again we had only ever been in the lounge so it would, you know it had always appeared and mum had engaged with Health even for some outside issues so it wasn't even just the stuff we were contacting her for, she had touched base with us a few times for help with potty training and you know those kind of things, so again on the face of it she looked like a mum that was loving, caring and –

HEATHER: And engaging.

MIRANDA: Engaging.

HEATHER: Yes she had struggled in the past but like you say –

MIRANDA: She had sought help!

HEATHER: Yes she had asked for help so I think it was during the visit the misgivings started to become more apparent.

MIRANDA: And she slipped didn't she, her parenting slipped and when the questions were asked you could see her temper a little bit more and you could certainly see the way the little girl was responding to the tension in the room.

HEATHER: Yes that is very true actually, and the way the little boy was as well.

MIRANDA: Yes very protective over mum wasn't he?

HEATHER: Yes and, yes it was quite apparent actually that he had an issue with his sister as well and they were both very negative about her and you know the little –

MIRANDA: I mean he even lashed out at her quite, you know, I mean I know siblings, siblings lash out at each other but I mean this little girl did nothing the whole time I was there, was quite submissive wasn't she and you know when this little boy got, you know for no apparent reason, I can't even remember that he was provoked by her in any way, you know quite viciously.

HEATHER: And mum did nothing until I said that you know 'I don't think that is okay' and kind of said to the little boy 'do you think you should say sorry to your sister?' at which point mum kind of gave lip service to you know, I don't think she said very much and she moved on very quickly but it became more and more apparent didn't it that she was very negative particularly to the little girl.

You said earlier that you thought even before you talked about it, that you shared a similar view of what was going on in the family, how did you know that you shared the same view?

HEATHER: Body language, looks.

MIRANDA: Yes body language, looks and it was the questions you were asking were the questions I was thinking.

HEATHER: And I was hearing what you were saying and your responses.

MIRANDA: So we were both kind of when either of us were talking I think we were both serving each other's kind of questions which were you know that were needed. It was, yes, I never felt that we were on a different page.

Right so would that contrast with visits that you might have done in the past where you were on a different page from someone?

MIRANDA: I think we probably both have visits where you can, you know, and it is not even just Social Workers, other Professionals can sometimes be on a different page because you are seeing things from different angles but all the cases we have worked on really –

HEATHER: Yes we have never differed, we have never –

MIRANDA: : We have respected each other's, if I hadn't thought of something in that way I have respected the fact that HEATHER is looking at it from that way so actually maybe I need to adjust the way I am looking at it to open my world and my vision a little bit more.

HEATHER: Yes but I think the same for me, you know like you say it is about respecting the other person's, we have got different agendas, we have got different roles and sometimes you have to accept that that means we are going to have slightly different opinions on things and it is about communication, we always talk to each other, always, if there is anything comes up –

MIRANDA: And it is accepted we have allowed I think, that is where I have struggled with other professions in the past is when you say 'I don't quite see where you are coming from and I am not quite sure that is what I am seeing when I am in the home when we are not together' that you are greeted with a 'well that's the way it is' and it is almost like your thoughts, you know I am on my agenda and I can't see what you are talking about.

HEATHER: Yes and 'I must be right'.

MIRANDA: Yes but you know certainly when HEATHER and I work together it is not like that. I feel able to be able to say 'oh HEATHER I don't, you know, I don't think I am seeing that' or 'I don' think that that is the way it is' and that's accepted and respected and I think that is the other way round as well.

HEATHER: Absolutely yes, yes it is that same space isn't it and that respect that has kind of built up but it is also just about making the effort, I was thinking on the way here I was really sure it was one of your colleagues the other day, I had not gone in from, I had gone to work at 7.00 am on the Thursday morning, I had got home at 1.00 am on the Friday morning having driven nearly 400 miles for some awful case and she rang me saying 'oh I have not been able to get hold of you for ages' and that was it! I really, I could have flown but I didn't but I was short with her, so I rang and apologised when I next needed to speak to her and it is little things like that, it's, we do it with our team, we are very good at saying 'oh I was really out of order the other day' but we are rubbish at doing it with other Professionals and if they are a little bit funny with us sometimes we are rubbish at accepting that they may be having a bad day and it is not personal. Whereas I think you and I we know it is not personal, we know if we are a bit out of sorts we are just out of sorts.

MIRANDA: Exactly and I know that when I leave a message for you, it will get picked up and if it is urgent I will in that message say 'I need HEATHER to phone me back today, I will be on my mobile on this number' if I am not in the office and I think again it is about clear communication, lots of my colleagues are not specific enough in the message they leave other Professionals and then will moan when they don't phone them back.

HEATHER: Yes and vice versa yes.

You talked earlier about the, not your words maybe, but you were talking about the possibility that you, the acceptability of change within your relationship so that it is okay to disagree with each other, why do you think that works for you two and maybe is more difficult in other relationships?

MIRANDA: I think it is a personality thing, a lot of the time, I am not always sure that it is a trainable thing. I think it is just the way you are. Some people are more able to see things from other people's perspective more readily than others and I think you are either accepting of that or you are not and I have got colleagues in my office who, it is not even just outside the agency –

HEATHER: They are quite precious about their views yes and their skills, yes.

MIRANDA: And you can't challenge on something because they get very defensive and they think you are being personal about their work and you are not, you are just actually having a little bit of a healthy challenge.

HEATHER: But I think it is also about respect of the other professional and their ability. I know that MIRANDA is sound in her judgements and in how she sees a case from what I have seen and from our work together so I am much more likely to listen to challenge if I am really honest than to somebody that I think 'oh you have got it a bit wrong there!' And then the next time you talk to them 'oh I am still not sure!' and so I think some of it is confidence and ability.

MIRANDA: And I think that is a two way thing as well, you know I don't always see things right and I see them my way as a professional but that doesn't mean I am not seeing the whole picture so I rely very heavily on my other colleagues in other agencies to be able to. So if I say 'I am not sure that I can see it that way' that they will be able to challenge me and say 'are you sure, did you not see that?' to help me be able to see it. It doesn't mean that it is about being wrong or right but it's about helping each other come, because at the end of the day the child is in the middle and our, we are all fighting for the same or we should all be fighting for the same cause.

HEATHER: But there are two things there, that is absolutely key the child is at the centre and I know that with some Professionals that is very apparent that it doesn't matter what we think as Professionals it is the child that matters and I think they are the Professionals that you tend to get on with and that get on with you. I think the other thing is 'challenge' is a big word and can sound quite difficult and aggressive at times and what have you, but I never feel like particularly 'challenge me'. We have a debate, we have a discussion, we reflect on a case –

MIRANDA: A conversation about it yes.

HEATHER: Exactly it is reflection and I think Social Workers are more open to reflection in their own practice and maybe a bit more willing to listen to the Professionals and the same with other Professionals, it depends on your practice style as well, some people are very black and white in what they see and how they think and some of them much more open to grey areas and much more open to being off centre from a case maybe and a little bit you know –

MIRANDA: And I think sometimes it is about I might not see something but you might highlight it to me, so the next time I go in, I will actually have that in the back of my head which I probably would not have been looking for before just to think 'oh you know HEATHER has planted that seed, let's just actually really look at that when I go in and see what happens' and then have the conversation when you come out, and say 'well actually you could be right, you know, you know this and this is going on' or actually 'no I tested that and I did really push that mother and I didn't see any of that'.

HEATHER: Yes and I think it is about hypothesis testing, you know in Duty work that is all you do, it is all hypothesis from the referrals going out, test them to see if they fit, see if they don't, see what is really going on and I think we do that with each other don't we? I spoke to a Health Visitor recently about another case and at the beginning she is saying this mother has clearly got significant Paranoid Personality Disorder, I said 'and we have debated a cognitive ability' and her first response was 'really!' and then she started to read through the notes, she said 'oh no, now I can see what you mean' and it is about that kind of just thinking, you know just thinking about it.

MIRANDA: But you are not always right, I think and it is okay to say 'I am not right and I don't know, I am not the expert'.

HEATHER: Yes exactly and it's a child who's poorly. Yes, yes.

Are there particular kinds of things that you might have a different perspective on? Or might have a different view about?

HEATHER: Well we really shouldn't find any because we work really well together, I am trying to think, it would be small things wouldn't it that we had sorted out along the way.

MIRANDA: Yes I think that is the thing, it is communication and I think if you are honest with the Professionals that you work with –

HEATHER: They are not an issue so you don't think about them.

MIRANDA: They don't ever get to the point where they are an issue and I think it is sad because I hear my colleagues you know having struggles with other Professionals and you just kind of think well actually why don't you just pick up the phone and actually say 'can we meet face to face to talk about this because I am really worried about this child and I am not sure that you are hearing my concerns' you know, so could we possibly, you know rather than just playing telephone tennis and leaving messages and getting frustrated.

HEATHER: Maybe, I mean every professional practice is different and that has a big impact but maybe it is about experience and ability and things, one thing that we struggle with, with some Health Visitors that I have never had an issue with MIRANDA is threshold, level of risk and I have had some Health Visitors who have been really cross because we have closed the case down. Whereas you know I have always found MIRANDA to be pragmatic about

threshold and I would say our thresholds are pretty similar in they could be managed at Health Visitor level what needs to be Section 17, what needs to be Section 47 and there has been one or two cases we have discussed over the years when we have not necessarily agreed fully but we have worked it through.

So can you give me an example of a situation where you might not have agreed about thresholds?

HEATHER: I am thinking of the one in the flats in ..., I can't remember where the flats are, it was a single young man with a small child, Selina was the main worker?

MIRANDA: ....

HEATHER: Yes, yes and we weren't sure were we about where that sat for a while?

MIRANDA: Yes and I think that was difficult because my student again was at a stage in her training where she needed to lead on some safeguarding but I ultimately was the case load holder so it then became a dynamic of three which became, made it more difficult.

HEATHER: Where we were coming from, yes to begin with.

MIRANDA: Because she was very insecure in what she was seeing because she was new to it so we did lots of joint visits together but she equally did some by herself so her concerns, the concerns were coming via somebody else which I was then trying to be the mediator between, it was very difficult wasn't it, but again another really really complex case.

HEATHER: Exactly and lots of grey areas, lots of concerns, niggles but not a lot of evidence to go with it. A lot of, I think like you say your student struggled more with it and you coming from her perspective to begin with because she came back to you and we had that conversation but again our working relationship wasn't damaged by it, we talked it through, talked through the concerns and I think in the end actually because I wasn't sure, I had held on to it for longer than I should have, timescales are always an issue in our team and actually I think we concluded, we came to the same conclusion didn't we?

MIRANDA: Yes.

HEATHER: We did keep it open but it is Section 17 and it kind of met the child's needs and kept them safe, you know.

MIRANDA: Yes and it did and that was an appropriate thing to do at the time because there wasn't, there was a very big feeling because we were going in and supporting this mum, you know weekly, so perhaps we had the clearer picture because we had that but there was no hard and fast evidence, there was just that gut instinct of working with a family that you know 'I am not seeing really what's going on here, I am seeing what you are showing me but I know from looking at this child she is very much telling me something very different' but you can't base a referral on that, you can't base a referral on the fact that this child is displaying some very peculiar traits, you need time to be able to unpick that, to work it, to get your evidence to be able to make it not just a professional gut feeling.

HEATHER: What I would say though again though our working relationship was such that I went out and did another visit which I wouldn't normally have done, probably maybe if I am honest I wouldn't have done it for the student, well we didn't do it for the student, but it is not just my working relationship with you because I have a good working relationship, my

boss trusts you through me, so when I went back and said 'this Health Visitor says there is an issue' he said 'well okay then reluctantly I will let you go out and visit again' because we normally have a one visit policy in Duty, we need to visit and move it on or close it and then I saw the evidence that you and Barbara had been alluding to so, yes.

MIRANDA: But it needed to kind of, sometimes I think as Professionals we are not very good, Health Visitors, at being able to realise there has to be sometimes some, an element of drift as well sometimes, to let the parents mess it up, to get you, to get that evidence you need to not parent the parent and Health Visitors do do that too much sometimes, we hold parents' up, we go in, we know there is a concern but we are concerned so we go in weekly but actually what we are doing is we are preventing that piece of evidence coming to light that would be enough to get the referral through the doors because we are parenting them and we are being those watchful pair of eyes and I think sometimes you need to step away in a safe way to let it unfold a little bit and then you go in and like that time we stepped away enough, we reduced our visiting and then –

HEATHER: And then I saw exactly what you said about –

MIRANDA: And then we went in and you saw exactly what we thought was going on but you, you know and I think that is where the frustration sometimes comes between Health Visitors and Social Workers because they think, Health Visitors perceive that from Social Workers to be that they don't take their concerns seriously and that they are not doing anything about it whereas I see it sometimes, maybe I don't know, maybe I just see it a bit clearer that you do sometimes need to let the parents' parent.

HEATHER: And it is quality of information and it is, I think sometimes as well Health Visitors have more autonomy than Social Workers particularly in safeguarding and the frustration isn't always with the worker and you are very, you understand when it is coming from a Manager and not from me and I feel safe to go to tell you that, and not suddenly get it back in an email via my boss you know, that is something as well, that level of trust.

So sometimes the decisions that you make together then have to go to a Manager in your Organisation, in the Social Work Organisation and they might make a decision that –

MIRANDA: Very different decision, absolutely.

HEATHER: That is different to the ones that you would make together.

MIRANDA: And that is where our Managers come from different angles and I think that is why you have to work so well together because sometimes you have to be able to do things that serves the Managers but equally are serving each other as well and do it and play by the rules but actually that is when working together works.

HEATHER: Yes and I think it is that trust, some of that trust with someone from a different agency to be able to have those conversations. You know you can always say to someone in your Team 'oh you know the boss doesn't want you to do this, how am I going to tackle it, how am I going to convince him that this needs to be done' or what have you, it is being able to have that conversation with you and work through it safely without like I say fear of it –

MIRANDA: And it is sometimes the option where like you can, like with that last family, I can't go in anymore, I have done what I can do and I can't go anymore, would you be able to offer this?

HEATHER: Exactly and we have done that before.

MIRANDA: Would you be able to go in and commit to once a week, once a fortnight and you know and although it is very not perhaps what we do but we make up a reason to go back in. Oh well this child had an eight month check but they were failing on a few things, I will use that as a reason to go back in because we are not Statutory so parents don't have to accept our service, we have to be invited in and they have to accept that they want something from us, so that can sometimes be really difficult finding a way to get back in –

HEATHER: We struggle with that.

MIRANDA: And when your time has finished it is really hard for these guys to be able to get that evidence so sometimes it has to be us who can think of a legitimate reason to go back in and like with that family over the time we backed off a bit but we still kept going in, then it was apparent something was going on and then you can pick up the phone and say 'I think I need you to come and have another look again'.

HEATHER: But I think equally we get cross because we forget that we are a Statutory Service and you are not and I think we get very cross sometimes, 'well we have told you to go in if you have got an issue go and see the family, you know, why can't you manage the risk in the community?' And I think we are really good sometimes at passing the buck without fully appreciating that you can't go in without invitation.

MIRANDA: Yes and if they greet us on the doorstep and say 'I don't want you here today' there is nothing we can do about it and if they say 'I don't want to see you anymore' all we can do is make a referral to say we have got a concern about this child, it is a gut feeling, it is really sketchy but they are now disengaging from our service and I have concerns because I haven't seen in that family home and the last time I did I was really worried about it.

HEATHER: And it is that managing of risk isn't it but I think sometimes we do expect you to manage risks that no Professional would be comfortable with, even Social Workers wouldn't necessarily be comfortable with but certainly other Professionals, where it is not your primary issue and you have got 3000 kids on your books and you know I think we do expect a lot sometimes.

MIRANDA: And I think that is probably why we work well together is we can actually see, we understand each other's jobs and I think not everybody understands each other's jobs enough to be able to have a little bit of compassion when you hear a colleague in another agency saying you know 'I really can't do that, I am sorry'. You know I think if you understand what Health Visiting is and you understand what being a Children's Social Worker is about then it's, you can, the empathy is there a bit more.

HEATHER: Exactly and the trust and it comes back to communication, you will say to me 'come on Katie don't be ridiculous' and I will say the same and you know ultimately that is what it comes back to you know.

Is it easier to feel that compassion towards HEATHER than it is towards Social Workers that you don't know so well?

MIRANDA: I think I always try and enter every relationship I have with a professional with an open mind. I rejoice when I see that {name of HEATHER} has referred something in and it is one of mine! Because you kind of just think 'I know this person, I know we are going to be

able to work productively together' and I feel secure and safe in that so I won't deny that, I would probably if I could choose a Social Worker for every one of my families then I probably wouldn't chose you know, HEATHER would probably be my choice but every Social Worker, I would like to think there is not, you know there is not many Social Workers that have a bad word to say about me or say that I am difficult to work with.

HEATHER: And I was going to say that is the only thing there are Health Visitors in the team, you mention their name and for a start people know them, like Sally this morning, we were having a laugh and a joke because my colleague held me up, you know who Sally is? Sally knows who you are and you can even have a joke, Val and me on the phone because there are some Health Visitors that we know well and we know we can trust, we know they are sound, we are kind of, and when I say we are on the same line it doesn't mean we are always coming at things from the same perspective but we are both focussed on the job that we are here to do and on the child's safety and we work well together, so yes MIRANDA is one of those names that comes up in the office positively every time. I can reassure you of that.

MIRANDA: Although I have been called the Pit-bull a couple of times in a Conference!

HEATHER: Have you really? Really!

MIRANDA: I get quite passionate when I believe something and nobody is listening.

HEATHER: Is that by a Social Worker?

MIRANDA: Yes.

HEATHER: That frightens me because I think you are just really sound.

MIRANDA: I think I am, I think sometimes if I feel passionately about something I am not, I am quite a calm person –

HEATHER: Yes you are very gentle.

MIRANDA: But I think when I really feel like I am not being listened to, I can have a bit of a bark and I am not afraid to sit round a Conference table and if I feel like we are not remembering there is a child in the middle of this and we are serving the parents' needs a little bit too much, I am not afraid to put my hand up and say 'hang on a minute we have spent too much time talking about why the parent can't parent these children, there is still children here, why are we not focussing on their needs a bit more?' So I think that is where some people find my directness difficult.

HEATHER: But I think that is where we in the Duty Team really like you. I think there is Team personalities in Social Work hugely. The Duty Team we are all told that we are far too outrageous, far too bolshie all the time but –

MIRANDA: See and I am told that yes.

HEATHER: But we go into houses every day where we have never met them, we don't know what risks we are facing, like today I went into a house where there is an arsonist who tried to kill his last family and you know this is what we do so we are quite ballsy, dare I say, you might want to edit that out. Whereas the Child in Need team or Safeguarding –

MIRANDA: They are a bit more touchy feely.

HEATHER: Yes and long term workers and particularly that mid to lower level of risk.

MIRANDA: Yes that irritates me the touchy, I can't, I like you know, I don't like people fluffing it around the edges –

HEATHER: That is not what we are here to do, it is not fair to the parents and I guess our values are similar.

MIRANDA: And I think we work similarly like that, I go into a family and whether it is Safeguarding or not and I am honest with parents about what my job entails and you know I will always tell you what I am thinking and if I have a concern about you or your children you will be the first person I tell'.

HEATHER: I was going to say we won't get a referral from MIRANDA where it says 'have the parents been consulted?' 'No' or if it is it is because it is an Urgent Section 47 –

MIRANDA: Or it is because I have concerns, it is normally domestic violence but have concerns –

HEATHER: You have got to be really careful how you do it.

MIRANDA: You know that you are going to put the child more at risk by telling them, telling the parent what you are going to do but you know I would always say 'you won't receive a letter from Children's Services on your doorstep saying they are coming to visit without me telling you' because that is just rude aside from anything else, I wouldn't want that happening to me.

HEATHER: But we often have trouble with other Professionals, even Health Visitors, although Health Visitors are better than schools where they think it is better for their relationship somehow to refer it to us and not tell the parents and –

MIRANDA: Because, and I have heard that word 'we are not sure so we don't want to break our relationship' and I am 'but you are okay for us to do that'

HEATHER: But also it is the worst thing they could do for their working relationship with the parent, if you have got something –

MIRANDA: It is going to come out that it has come from them isn't it?

HEATHER: Well we are not going to hold it back, we are not going to be anonymous about it and but again you get that, you know you are –

MIRANDA: Lots of professionals are afraid of safeguarding I think and you know I have worked with many a Health Visitor who, the trouble with safeguarding and Health Visiting is you can either see it or you can't and you can choose to not see it if you really want to and if it scares you enough you can really choose to not see what is going on and you can find yourself colluding with that family and excusing behaviours because you are afraid of what will happen if you stand up in that room and say 'I don't think this is right, I think something is going on here' and you know that's for that Professional I think to deal with but I am not afraid to challenge that in my Professionals that I directly work with either.

HEATHER: But parents respond to you well because you are honest and that comes through.

Do you ever feel it is difficult though because one of the things that is different between your work and HEATHER is that you are likely to carry on working with families, whereas HEATHER might only see them once as she said?

MIRANDA: I genuinely find that lots, most of the families that are my safeguarding families that I have made the initial referral for, I always offer parents 'if they want to change Health Visitor I completely understand' because I am the big bad wolf and you know I understand that, that's fine but most of them want to keep me because there is that sense of security that they know I am going to be honest, they might not like what I have done and they might give me a gob full for it and they might tell me they never want to see me again the first time I go back round there but then when you give them the option of saying 'okay well you are going to need a Health Visitor anyway because of this process would you like me to refer you to somebody else?' they will then turn round and say 'no' and once you are starting working with them again they will say actually, you know lots of them can be quite reflect full and say 'actually now we can see that things weren't going the way they should have done and I am glad that you did do what you did and we trust you now because we know that you are going to be honest with us and you are going to tell us exactly what you expect of us' and there isn't that kind of grey area where some Professionals are not direct enough in what they tell the parents they expect.

HEATHER: And you know you say about fluffy Social Workers, I think fluffy Professionals in general are a big problem for families, they are not given the truth, they are not giving them a chance to put it right.

MIRANDA: It's unachievable targets then isn't it?

HEATHER: Exactly or they are just not aware there is a problem and another problem that I think I am aware of for Midwives and Health Visitors and I try to be sensitive to, is they are rooting for the parents to keep the child whereas sometimes if we are really honest we are rooting for the parents not to keep the child because we don't think it is in their best interests and new borns particularly, I have just been dealing with a new born who is now not in mum's care. It is incredibly hard for a Health Visitor where their whole job is promoting with a new baby and you know this mother was breast feeding and in hospital apparently doing okay for the first couple of days and it is really difficult and I think that must be very hard, I find it hard and it is not my job to promote that kind of mother baby bond. It must very hard.

MIRANDA: I think it is hard but equally you have to put the child, again lots of Professionals it amazes me lots of people are unable, we are the parents' advocates, we are trained to be advocates for family but the lead person in that family, the way I always took from my training was the child and the parents are not the lead person in a family when you are looking at child protection, the child is, and our advocacy should be more for that child that can't speak. We should be the voice for that child and if we think parenting is not adequate enough for that child to grow and develop normally then it is our responsibility to put our hands up and say 'I don't think you are doing it right' it doesn't mean, you know I always say to parents 'I am not saying that I don't think you can do it' I am just saying 'I think we need to help you because something is not working out' and you know –

HEATHER: And I have to say the one that I have just dealt with, it is another Health Visitor through, I have had a lot of dealings with the ... Office lately and she was great and she was

very straight down the line and actually quite relieved that we had intervened because she was so frightened but I have equally seen cases where they have really struggled with the fact that we have removed the child, really struggled.

MIRANDA: Because they can't see past the parents' need can they?

HEATHER: And I think we aren't always very helpful in that though because I think we can be so for the child, we can be quite negative about parents and sometimes inappropriate actually.

MIRANDA: But that is where I think a good working relationship needs to be because –

HEATHER: If we can both vent –

MIRANDA: Yes, I think if you are then overly seeing it from the child's needs but you are not looking at the positives a parent might be able to bring and the opportunities that maybe there is an opportunity that this parent with a Mother and Baby Unit or some intensive support, they might be able to turn this around, that is where I think the good relationship should come in, that's when the Health Visitor should say 'I agree with you, the child at the moment, the best place is not, it is not safe for that child to be at home with that parent but I think there is an opportunity to be had here and I think we should explore it before we dismiss it'.

Do you think that sometimes you are able to persuade each other of a different approach because of that interaction?

HEATHER: Yes I think we have all the way through persuaded each other on the same case maybe two or three times because we will, I think, I mean I think the roots of Social Work, of Social Worker's reflection and I think as Professionals working together the root is reflective practice between different agencies, between Professionals. We will both sit and reflect on a case, we will spend half an hour on the phone sometimes just tossing backwards and forwards.

MIRANDA: And even ones that we initially haven't, the recent one where you have picked up but I was involved way back ages ago with a different Social Worker and it has now kind of all started to, and I have spoken to you about it and what you are seeing now were my concerns in the beginning but they, yet again there wasn't evidence to be able to take it any further and luckily now things seem to be starting to move again but it is even though you weren't the Social Worker at the time it is just nice to be able to hear that you know –

HEATHER: That we have seen it and it is edifying for your practice as well isn't it? I think it is really difficult when you are that lone voice you know in the desert if you like saying 'I am worried about this, I am worried about that' and all the Professionals going because that case last time it was taken to Conference and everyone decided to send it to Section 17 much to your upset and looking back I'm thinking 'really!' but at the time you were the lone voice of concern and I think sometimes it is nice to get that, and I will tell people if I think that they have made sound judgements and you will do the same and I think that is incredibly beneficial as well because it is tough being the only one who has a concern, you start to doubt yourself and doubt your practice or worry for that child for ever more.

MIRANDA: I think some Health Visitors in doing that are now fearful of doing that so they then sit round a Conference table and be the last person to make their vote and they will go

with the majority because they are too afraid to actually say you know 'I don't think and I want it noted that actually I don't agree that we should be leaving Child Protection' you know and I am not afraid to say that without you know the colleagues round the table looking at me and giving me daggers. It is respected that it is okay I am allowed to say 'I agree with the family has made progress and I think it is wonderful but I don't think we are in a place where we should be ceasing this plan and I want that noted in the Minutes'.

HEATHER: And I have to say that I really think that if you and I were at a Conference for a case and we were on opposing side if you like and our views were opposed either way, I was saying not Conference or not Plan and you were saying yes or the other way round, neither of us would have a problem with that I don't think, I don't think either of us would struggle because we would have had that conversation way before we got to Conference and we would both feel quite comfortable encouraging the other one to have their say and to have a differing opinion.

MIRANDA: And it is about not wanting your way isn't it? I think you have got to accept –

HEATHER: It is not professional smugness?

MIRANDA: Yes you have got to accept that it's, you know you might have a different opinion but it is not about right or wrong, it's about being able to say 'I have a different opinion' and you have a different opinion that's fine but I just want my opinion noted'.

HEATHER: And it's not personal that's the key, we don't take it personally. I have had Professionals, Health Visitors sometimes ring back just to say 'see I was right' and that is really not helpful!

MIRANDA; It is childish isn't it apart from anything else!

HEATHER: Incredibly so and I am sure Social Workers have done the same and it is not helpful, whereas I know that if you have had concerns and I haven't and then I have, you would never do that, we would kind of discuss it and that is really important to have that –

MIRANDA: You have to respect that people are seeing things from a different perspective to you. I see safeguarding as one big giant puzzle and every professional that is involved in it has a piece, they don't have the whole puzzle, it is only when we all sit round a table together that the pieces are put together and we all truly get to see what probably really is going on in that family home. My piece of the puzzle is only a piece of the puzzle and I can only offer it and it is only when you have got all the pieces together that you should then be able to make a decision and say 'okay yes I agree I thought my piece was really alarming and I was really worried but I can see when you put that altogether that actually yes maybe –

HEATHER: It is manageable yes, yes.

Does your piece to continue your analogy which is a nice one I think, does your piece contain knowledge that comes from your professional perspective, from being a Health Visitor that makes your perspective slightly different from being a Social Worker?

MIRANDA: I think yes probably, my background has always been health, I have only ever been a nurse so you know my perspective is always going to be grounded in the health of a child and their growing and developing so I think my piece of the puzzle is but I would like to think that in Health Visiting I learn from all my colleagues that are around me, there are bits of my practice that are rooted from my colleagues that I have learnt you know from Social

Care, even back to nursing on an acute ward Obs and Gynae, you know having to be in multi-disciplinary meetings with Consultants and people that very much disagree with your plan of action but being able to say 'I don't agree with' and not letting stature in an organisation make you feel like you haven't got a voice, your voice doesn't necessarily need to be heard but you should be able to say 'I don't agree with you' and especially in safeguarding I just think you know you potentially might be the only voice for that child and you need to, it might not change the outcome but you need to at least, I need to at least know from my professional judgement and for my personal wellbeing that I have voiced that child's concerns to the best of my ability.

HEATHER: I think I have learnt from Health Visiting colleagues, I have learnt how vital health and development can be sometimes in the evidence that we so dearly need and can't find sometimes, it is very useful.

MIRANDA: And the children will give us the ...

HEATHER: And we have to learn that because we are not taught as a Social Worker ever to work with children and what we don't know to very specific points are things like developmental checks and what have you and the joint protocol is positive in that we do go out with the Health Visitor because it is just watch and learn and listen from them and learn some of those specific questions that you ask that are so telling that we would never in a million years think of asking that could be incredibly useful and I think we are 'Jack of All Trades and Master of None' in Social Work unfortunately.

MIRANDA: But I think Health is a little bit like that as well, I think you know it is only when you put the pieces together that you see the whole picture.

HEATHER: We learn from each other don't we?

MIRANDA: Yes.

HEATHER: Like the stickers, I mean that is an ongoing joke but that was incredibly useful and I remember a foreign little boy who didn't speak any English after I had worked with MIRANDA on that case and discovered the art of the stickers, I had a whole conversation with him in his language about Peppa Pig because I found some Peppa Pig stickers and put them on my book and actually it was incredibly beneficial in terms of observing his development and where he was at and what his general kind of you know emotional state was like, so there is little things like that that we learn hugely but in the office we do tend to think of Health Visitors as pretty much Social Workers who see everybody, almost, I think we recognise the discipline as being a very positive, Health Visitors are definitely spoken of more positively than Teachers or Child Abuse Officers in the office.

MIRANDA: I think on the whole in our office we all know our Social Workers, we all know our Social Workers' names even if we can't get hold of the named Social Worker for a family we know which Social Worker we can kind of ring and just say 'Oh I don't suppose so and so is about are they?' or 'can I just' you know.

HEATHER: Not like one midwife bless her, she had only managed to get hold of her boss's number so every single person she wanted to talk to in the office she used to ring him, he got very cross! He is not the person to ring!

I wonder where that sense of knowing what you know comes from then because you talked about a lot of similarities in your roles, you talked about a lot of learning from each other so do you have a sense of having a kind of body of knowledge that comes with being a Health Visitor, that comes with being a Social Worker that is retained, that you know something …

MIRANDA: Well I think that is your underpinning, I feel that it is my under pinning knowledge, I always fall back onto my nurse training whether that is nursing or whether that is Health Visiting that underpins everything I do but I am not closed off to learning bits from other, you know midwives, GPs, I am always learning or hearing people say things, I think 'oh that is a really good way to word it'.

HEATHER: Yes absolutely yes and I think in Social Work we have our knowledge skills and theory that we talk about from day one of Uni all the way through, again and again and again and you know professional development is a big thing at the minute particularly with the HCPC coming up but I change all the time, if you asked me six months ago what my knowledge and learning was it would be much less than it is even now six months later, I think like you say –

MIRANDA: You don't ever stop learning.

HEATHER: No, you take it in like a sponge and it almost feels at the minute the more experienced I get rather than getting more set in my ways and set in 'I know what I know and that is all I know' I seem to be learning at an accelerated rate, it is almost like I desperately crave more and more information, more and more knowledge, you know if you look at attachment, you go back to your basic attachment theory when you do your degree and then to where I am now and looking at parenting styles and child development styles and what are factors and you know, your knowledge just changes all the time doesn't it and feeding in from other Professionals makes a big difference in that in my experience watching the health side of things.

MIRANDA: Because our training you know is very different but it is a variation on a theme but the continued professional development training, we get very different things so I think what I learn in the training that I go on, can be drip fed to other Professionals and vice versa because you know it's cashing in on what other people have learnt and your Trust hasn't bought into.

HEATHER: Exactly and it is little details sometimes, in my head I guess my learning is all about evidencing what life is like for a child whether it is good bad or not because that, in my job particularly now that is my focus, I write assessments all day long, it is all I do and just like the new born baby that I have dealt with recently, it is little things that the Health Visitor and the Midwife have said that I thought 'that's really really good evidence that I never would have seen had they not said it' and it all goes in and all gets ferreted away and put there until the next time I might need it or it might be useful, where it is another question like if I ask a parent that might actually give me a better insight as to where their head is at so yes I think that learning just goes on and on and on really.

MIRANDA: I think it is dangerous when –

HEATHER: You stop!

MIRANDA: You have Professionals who think they know it all now and they have done enough.

HEATHER: Yes absolutely.

MIRANDA: I think you can't ever in this job and certainly focussing around safeguarding you can't ever claim to know it because I think that is dangerous, a very dangerous place to put yourself.

HEATHER: Absolutely, I think you are absolutely right there and I think the minute you stop questioning your own motives, your own agenda and then the Professionals and then the parents, then you need to walk away and do something else, yes.

MIRANDA: Yes and a lot of safeguarding is about putting your own standards very much at the door when you leave, I know you know working with our student Health Visitors it is very difficult sometimes to get people to understand the threshold of 'good enough'.

HEATHER: Good enough yes absolutely.

MIRANDA: That is not my 'good enough' that is not your 'good enough' and that is your good enough, that is what is good enough for that child to grow and develop, that might not mean we want to live there and that might not mean it is ideal but you have to leave your standards at the door and it is about that child growing and developing normally and sometimes you have to accept that that isn't good enough in your world, you think but that child is reaching their milestones, they have a beautiful engagement with their parents and sometimes that is just enough.

So where do those standards come from if they don't come from your own experience?

MIRANDA: I think it is from, for us it is an observation of the child, it is their milestones, making sure that they are growing and developing normally, that you know there is a good bond and attachment with their parents even you know new born babies can tell you a hell of a lot about what is going on in that family home.

HEATHER: A huge amount yes.

MIRANDA: You know without, I find babies easier to work with in safeguarding than children because babies there is no, they will tell you straight off just the way you put your head in that cot and you go to pick them up they will tell you straightaway whether they are rough handled, whether they are used to being cuddled, whether you know, without telling you they are a blank canvas for you know, they might as well just have a sign on their head saying exactly what goes on and I think it is about observing those milestones and reading children's and babies' cues and if everything looks like it is going right then you have to accept that's what's going on around the outside –

HEATHER: May not be the best and it is about, I think a frustration in Social Work with the Professionals is they don't look at what they hope to achieve sometimes, why are you doing this? It is not just about what you observe now but it is about where you hope to end up particularly the way services are and thresholds are now, where it is so hard to even get a child open to Children's Services let alone offer a service. Our Service is poor compared with where it was five years ago in terms of what we can offer a family, we don't have other Services available and it is a case of 'is it good enough? and can we actually effect any positive difference you know in Social Work' we are constantly asking ourselves right from

the very top of risk to you know 'are they better off at home or in care?' Right down to the very bottom 'what can we bring to the party that can't already be offered and will a Social Worker involved in that family really make any difference given that they might only visit once a week' sorry not once a week, once every six weeks for an hour. What do we hope to achieve? And I think that Health Visitors are generally better actually than other Professionals in understanding that because you are used to having a rubbish service so maybe a bit more pragmatic about it! Other Professionals really struggle with that well it has to be a Social Worker and it is –

MIRANDA: They think you are the almighty don't they and that you can make it better?

HEATHER: Yes and we have got a magic wand but also I think people are struggling to keep up with the, 'what do you hope to achieve?' Which is the main focus now of Children's Services or Social Care but not necessarily the focus with other professions and that is a tough one and it is a tough one to impart, I think Professionals can get very frustrated with us when we say 'but what is the point of our involvement?' And it goes along with the 'good enough' you know. We will often get referrals from the Police to say the house was a mess and you go out and there could be yoghurt pots on the floor that haven't been picked for a couple of days.

MIRANDA: And then on the flip side of that you get Police reports of ones that say 'things were okay in the family home but we think mum is wanting some parenting advice' and you go round and you think did you miss all –

HEATHER: Yes the three foot of debris on the floor!

MIRANDA: There is no way this happened overnight and seeing that this family only came in a week ago there is no way this house could be in this state in a week, you know, so I think again we find our relationship with the Police very difficult.

HEATHER: We do too.

MIRANDA: At times because –

HEATHER: Uniformed Officers particularly.

MIRANDA: Yes and they, I mean I don't know about you but they like to shy away from safeguarding

HEATHER: Oh yes yes!

MIRANDA: And if you slightly want to say 'I think that is not good enough' to a point I had a Police Officer the other day refuse to do a joint visit with me where a father who was known to be extremely violent to Professionals but mum had asked us to go in, it is not their place to do that.

HEATHER: And we are struggling hugely, we are going from extreme to the other, to we had a uniformed officer decided to take a written statement from a thirteen year old without an adult present the other night.

MIRANDA: And interrupt domestic violence with using the father as the interpreter who was the perpetrator of domestic abuse, they like to do that one.

HEATHER: Yes that is another favourite but then we will go right from that extreme to one really really serious domestic violent perpetrator who is now living with a very little child, we had asked for a visit between the hours of 2 am and 5 am because we are trying to find out if he is living there or not, he is on licence he shouldn't be there and the Police said 'no we are not going because we will wake the children up' and it is just they... don't they and yes they can be very challenging.

MIRANDA: They kind of either use a sledge hammer to crack a nut or they actually just don't see it at all.

HEATHER: It is just an avoidance isn't it, a huge avoidance at times, so yeah I think Health Visitors are by far the best profession to work with.

MIRANDA: Because we work together quite a lot whether we want to or not, our roles you know –

HEATHER: But I think we also manage risk in a very similar way actually, we are lone working, we are going into an unknown for the first time on our own most of the time, you know the Police don't go anywhere without a friend.

MIRANDA: And they have radios to work wherever they are.

HEATHER: And handcuffs and you know whereas somebody tried to hold me hostage the other night and all I had was my diary and the threat of calling the Police if they didn't behave.

MIRANDA: And that is if you have got a mobile phone signal!

HEATHER: I didn't!

MIRANDA: If not you are a sitting duck.

HEATHER: I didn't tell them that, I didn't tell them that and I was way off the road, nobody would ever have found me.

MIRANDA: It is the art of bull shit!

HEATHER: But they let me out after twenty minutes yes so that was fine but yes I think we do approach work very similarly actually, like you say you go back to see violent families on a regular basis without necessarily anybody else being there because your focus is the child. I think that is where we are united really, you know to talk to schools about DV or any kind of risk to a child and they really don't want to know and we are getting told –

MIRANDA: They didn't want to talk about it with mum because you know they are saying they might come and -

HEATHER: They might come and shout at us, yes.

MIRANDA: We don't really want dad coming and kicking off in the playground.

HEATHER: And all we ever get told is 'we are not Social Workers' which makes it very offensive to Health Visitors who do a very similar job and yes other Professionals are very risk adverse they are not used to that visiting just off the cuff to a family that you just don't know what you are going to find, they are not used to thinking on their feet in the same way. So I think that's, I know we talked a lot about similarities but I think that that is really valid

actually because you know where we are coming from before we even do it. I was talking to a Child Abuse Officer the other day, they know what we do, we work with them so closely on a daily basis and we get on better than normal Police Officers but they were horrified that we were going to families where there was a level of risk to us and we were going on our own and we did kind of suggest what is going to be added by taking somebody else, we still don't have any handcuffs or CS spray, you know, we are cautious but we are not going to escalate it, we are not going to make it worse for the family, we are going to respect them in their behaviour but you do the same on a regular basis, you understand our perspective.

MIRANDA: In those situations sometimes you have to do an element of collusion to be able to get in to do that assessment, and they are the ones where sometimes you are not honest in the beginning, you are constantly assessing the risk while you are there and you pick your battles don't you?

HEATHER: And then you can be honest.

MIRANDA: Because the most important thing for me is to get in and see what is going on in that family home. If that means I have to collude with them a little bit and I have to you know laugh and joke at dad's very you know –

HEATHER: Awful jokes.

MIRANDA: Awful jokes and you know he is wandering around like a shark in the room and this poor woman is practically quaking and you know I have to avoid any questions that would trigger him off, then I will do that to then come away and then make my assessment and referral if it needs it.

HEATHER: And then we will do the joint visit where we are more blunt about it but you would expect to be as blunt as us about the issues?

MIRANDA: Yes yes.

Does that ever feel uncomfortable when you are doing that?

HEATHER: Yes.

MIRANDA: I think yes there is very few visits where you have concerns about children where you don't feel uncomfortable and nobody, I still don't like telling families that I am concerned enough to make a referral to Children's Services but I have learnt you have to sell the service and sometimes it is about how you deliver it and people perceive Children's Services to be big bad wolf, to be the ogre 'they are going to come and whip my children away from me because my friend you know all she did was go down the garden for a cigarette and Social Services came and took her children'. You know and they all believe that Social Services is a very negative thing whereas I sell the Service in that 'well they have got the tools to be able to help you more than I can, I am still going to be involved but I need to speak to my colleagues in Children's Services' and we kind of sell it that we are one and the same. 'I am going to talk to my colleagues in Children's Services' not 'I am going to refer to another agency' so that they kind of think 'well I feel safe with you and the service you are offering, what you are doing is just having a conversation with your colleagues in another office and we are going to decide whether there is something we can do together to support you'.

HEATHER: But I think you say about having to say certain things to get into a household and you know in Social Work particularly if you are trying to get a parent to willingly agree to put their child in care because you have not got a Court Order yet or the Police aren't willing to protect, Social Workers, I am a very blunt and to the point person particularly in my practice MIRANDA will tell you but it is uncomfortable every time that you have to almost, it feels to me like manipulation, manipulate the circumstances to keep yourself safe, to keep the child safe, to keep one of the parents safe and I always try and be blunt and honest as soon as I possibly can be in a safe way, if I am not going to be able to be completely up front at the beginning and I have learnt to just say to parents 'I can't always tell you everything I just can't but I will tell you what I can, when I can' and that makes me feel a little bit better and they feel better because then they know that you are going to keep things from them sometimes so they don't feel quite so cheated by that and they know that if you can be blunt you know I find the blunter the better really, they hate you for about five minutes and then they are pleased that you have been honest so it then generally works better but it is uncomfortable to, the, where I was held, I mean it sounds very dramatic, held hostage but they refused to let me leave and they ran to stop me getting out of the door and they were very very angry and threatening to harm me and I feel terrible because I just let them say whatever they wanted to say and I just was very calm and encouraged them to say whatever they wanted to say until they had calmed down and for me to get out and that still doesn't feel very, I would still like to go back and tell them exactly what my thoughts are about what they were saying so that they are really clear but ultimately I guess it would have been worse if their house had been raided by the Police and what have you so you know it is difficult isn't it, I hate not being fully upfront at all times.

Lindsey: It is difficult but honesty is best where you can, I find being honest –

HEATHER: And just be honest when you can't.

MIRANDA: Yes and you know when we have to follow up Police Reports of either domestic abuse in families or you know or there has been an altercation between parents and the children have been present you know they know why, as soon as I knock on the door I say 'do you know why I am here?' You know.

HEATHER: Yes they are not idiots, you don't always have to spell it out.

MIRANDA: And they are like 'because of the Police' 'Yes shall we have a little chat about it?' Whereas I know some of my colleagues they won't answer the door or they will open the door and give them a few explicits and say it is nothing to do with you and slam the door in their face whereas I do lots of negotiation on the doorstep sometimes before I am let in and I think again it is about them just seeing that you are being human about it and you are not making judgements straightaway. You want to hear their side of the story because I often say 'I only know what the Police report has told me and that is what the Policeman has perceived it to be, maybe there is a bigger picture that I am not seeing'.

HEATHER: I often find myself saying something very similar 'look I am here because I want to know your perspective, I don't want to know what everyone else thinks, I want to know what you think and I want your story first that is why I have come to see you' and that often helps calm them down a bit so they are open –

MIRANDA: And then will kind of quite happily let you in and tell you about the argument, dispute with the neighbour and what is going on and –

HEATHER: And how it awful it is and then at the end of it then you have to say 'Oh I am really concerned!' And then that is awful!

MIRANDA: Can I come back again? Can I come back?

Why is that bit awful HEATHER?

HEATHER: I feel like I have cheated them, people love to tell me their whole life story and then –

MIRANDA: And then you feel like you have set them up.

HEATHER: Well absolutely and I did that to the family that we started talking about today, do you remember how cross she was with me because she told me everything and then of course it is all in my report for Conference and in black and white, it is really hard for parents to take.

MIRANDA: But that is always the art of what we do [HEATHER: and that feels slightly underhand}, you almost have to, it is a little bit of almost have to befriend people to get them –

HEATHER: Well to certainly get them talking and opening up.

MIRANDA: To get them to give you the information and like you say it is sometimes really[HEATHER: they really hate you] hard when you then have to turn round and say 'well I am actually really concerned about what you have told me today' because they look at you almost as if to say 'but you asked me to tell you' –

HEATHER: And a classic thing in Conference or in Court 'well I never said that' and you go to your notes 'well you said this this and this on this day at this time' and you can see their anger 'but I said that to you I didn't say that to you as a Social Worker –

MIRANDA: No I told you as a visiting person to my home.

HEATHER: Yes even though you have been really and I find it doesn't matter how blunt or up front I am with people and how clear I am about my role and –

MIRANDA: They don't hear it.

HEATHER: Yes they don't until they see it in black and white or hear it said in a formal meeting and then they feel completely betrayed. I struggle with that even though that makes me quite good at what I do, I struggle with that.

As a person?

HEATHER: Exactly.

MIRANDA: Yes and when you take off your hat of whatever profession you are you do sometimes sit there and think oh I feel really awful for doing that!

HEATHER: Well exactly yes.

What is the source of the awfulness though?

HEATHER: I think it is just the personal, I think it is that you know you know that you are acting in the best interests of a child and you are doing what you need to do, you know in

your head that that is what needs to happen, I think it is the human in you just thinks I feel like I perhaps leered them in a little bit.

MIRANDA: I think if it was my friend and I was talking to my friend, not HEATHER the Social Worker but just HEATHER I would be screaming at them shut up stop telling me this, this is making things worse, you are going to lose your child –

HEATHER: You need to just be quiet now.

MIRANDA: Yes if you keep saying that and of course that is the one thing that is really unhelpful in terms of understanding what is going on for the child so I have to just let them keep talking and I write it all down and then I use it against them, that is how me the person sees it, I use it all against them because that is how they perceive it. I am not using it against them I am using it to safeguard the child but to them I have turned against them and I am using it all against them and I find that very uncomfortable. I find that –

How do you manage that because you said it is a key, you both said that's a key part of the job, it is something you both have to do?

MIRANDA: I think it is talking about it, I think I use my colleagues and other Professionals you know I will, if I have had, like after the joint visit we did for the initial family we sat in the car and talked about it afterwards, we talked about what we thought, you know you just, even just in a very basic way just say 'oh my God that house was disgusting!'

HEATHER: And if we talk to each other later on about another cased, we will catch up and we will debrief at times because that helps doesn't it?

MIRANDA: And things have improved you know it is nice to hear sometimes, to be able to say 'oh you know I have been doing work with so and so and do you know what you wouldn't recognise them if you go in there now'.

HEATHER: And that is wonderful to hear particularly just doing the front end but in terms of dealing with those difficult feelings I don't know how I manage them really they stick with me every time I take a child away I feel incredibly mercenary and as though I have betrayed parents even though it is absolutely, and you know don't get me wrong it is absolutely the right thing for the child and I know that, I wouldn't do it if I didn't whole heartedly believe in that but it is a very unnatural thing removing children from their families and I feel heinous sometimes for doing it and it is just a case of using that I guess to make sure that you are honest with families and you give them every chance to change and every chance to you know work with you and it stops you getting power happy I guess and stops you getting you know caught up in the buzz of it and it makes you circumspect and I guess that is where I am at really, I just reflect on it until it is no longer a problem. My boss who hates removing children also the other day actually had to say to me 'you do realise you did a good job' because –

MIRANDA: Yes and I think sometimes you need to, I think certainly I would agree with that as being part of the system that gets children removed sometimes you know, you do feel like you are part of some big conspiracy against these parents because they will have you believe that that is what is happening to them.

HEATHER: And essentially we are one big conspiracy because we are all working together against those parents in their head.

MIRANDA: I don't think you ever learn to deal with it though, I think if you are good at your job it will haunt you what you do, I think it has to. It worries me when people, I hear people say 'oh I get used to it'.

HEATHER: Or 'I like it' somebody said the other day that was freaky.

MIRANDA: I just think you should never, it should never be something that rests easy with you and that element of my job is not, it's the most enjoyable but not enjoyable because I know I am doing the best for a child but I don't enjoy the process of it.

HEATHER: It is compelling isn't it? We were trying to come up with the right adjective for our job the other day, myself and a Safeguarding Worker and we said enjoy no, satisfying no, fulfilling definitely not! We are compelled to do it, is where we came to in the end.

MIRANDA: Yes and I think it is that urge to make sure that you want to protect that child where nobody else, nobody else is doing it for their child and if the people that were put on this planet to protect them their parents cannot do it then you feel compelled to step in and say it is not working.

HEATHER: Somebody has got to protect those children and it is just an inane sense I think in Safeguarding Workers that whatever profession they are coming from that those children have to be protected almost at all costs and certainly regardless of personal cost to the worker.

You said a little bit earlier HEATHER that you don't always know what the outcome is and in fact –

HEATHER: Very seldom.

You very rarely know what the outcome of your work is?

HEATHER: Yes that is interesting, sometimes you might be glad not to know the outcome if they have messed up your Care Plan or they have sent children home when they shouldn't or you know so I find it best not to ask about certain cases. Certain cases I don't mind asking about but sometimes not seeing a case through can be really difficult if you have grown fond of those children, which you shouldn't because you are meant to be detached, but you do. I think children, you know, you become very involved in some cases because they are very full on and that is all you do for three or four weeks and they are difficult to let go but actually most of the time I am quite glad to manage crisis and then let it be somebody else's problem.

MIRANDA: I was then going to say the same. Yes I think whereas we get to see them through the majority of the time unless they move out of our case load area or they get adopted we then, we see them all the way through and quite a lot of them stay on the case load so you know and they might bob in and out of Child Protection quite two or three times and I think that can sometimes, I sometimes would quite like to start something and then kind of –

HEATHER: I am a short term worker through, I did child sexual exploitation work last year for nine months in, it was a joint task force with the Police and I had the same caseload for the whole nine months and I nearly went insane by the end of it, I have got a very low bond threshold and I get frustrated, when you are a short term worker you can be very very honest with people because if it doesn't pay off and they hate you, you can pass it on to

somebody else and they like that new person because you are not like that horrible HEATHER who I hated.

MIRANDA: Who said those horrible things about me?

HEATHER: Exactly, I get frustrated having to play happy worker sometimes which I think in long term work is more of a –

MIRANDA: And it can be draining.

HEATHER: Yes and I think it is a skill you need more in long term work, you have to placate people maybe more. I find it is plenty to do that with Professionals and to build that working relationship with Professionals but I don't necessarily want to with families or Foster Carers. Foster Carers are the bane of my life working in Looked After Children it is trying to keep Foster Carers happy that drove me nuts and I think I will never like long term work as a result of that because they are tricky beasts, parents are much easier. So yeah there are pros and cons to never knowing the outcome of a case and I have learnt not to ask I guess because I have heard some dreadful or what I would think from my initial involvement to be dreadful outcomes. I think that is one of the main frustrations of working at that front end is that the Care Plan changes and you wouldn't necessarily agree that it should but then again you talk to your Health Visitor colleagues and they are not necessarily very happy that the Care plan has changed either so that is quite satisfying, it is quite nice to have that conversation.

MIRANDA: And that is when it is difficult I think for Social Workers because somebody does the, like HEATHER does the initial work, sees this family at their worst and sees the horrible conditions potentially these children are living in and then it gets passed to someone else who potentially they might have, the parents might have been able to pick it up a little bit since then –

HEATHER: Well I have told them exactly what is wrong and then they listen to me, how dare they, yes.

MIRANDA: Yes yes but then these people will always see what they, their first contact is always what their first contact and I think that is where people don't empathise enough with Social Workers is that they haven't been, because we have normally been involved from the beginning they have not been involved from the beginning so they have not seen what we have seen so sometimes it is really difficult because you have to start, you feel like you are starting the core assessment element from the beginning when a new Social Worker comes in because you have to keep reminding them. I mean I have got a family at the moment, it is not yours, but it is a mum who is you know a drug user and has had her children taken away when she has a relapse and then she will pull herself together and the kids go back again and then she will have a relapse and then the children get, you know and I have been the constant professional. We have had two or three different Social Workers and I just got frustrated the other day and I said because mum has pulled herself together again so the kids are going back and I am very against it, I said 'how many more chances does this mum need at a detriment to her children?'

Do they listen to you, the long term Social Workers?

MIRANDA: Well the Social Worker's response to that was she has got to be given an opportunity. I said but she has had three, you know this might be her first opportunity with you but I am telling you this is what she does, she will pull it together, she even said to me

this last relapse she had, mum I said to her 'what has gone wrong?' She said and because she was off her head, it is like truth serum it was the first time I think she had ever been honest with me the whole time I have worked with her, I had suspected she had never been clean but she had –

HEATHER: She had been able to hide it yes.

MIRANDA: But because she was high as a kite when she spoke to me she said 'MIRANDA I have never been free of drugs' so in her world she doesn't see why she needs to be clean because she has never been clean.

HEATHER: And yet we keep returning the kids to her.

MIRANDA: And I said this to the Social Worker, I said but this is what she does, she, I have seen you know, I have worked this caseload long enough to know who the drug dealers are around here. I know them, I have seen them, I know who they are, I said I phoned you up today and said yesterday the biggest known drug dealer was banging on her door, I saw her answer the door, she saw me because I was driving past, quickly hurried them in so the Social Worker I told it to and I said 'you know he is, he has just gone round the property about fifteen minutes ago she is supposed to be clean'. Mum told her, the Social Worker because she did go round there about half an hour later, 'yes he was here but he had come to collect a bike lock' and I said –

HEATHER: Really! But then you see –

MIRANDA: I said that worries me that you believe her, I said –

HEATHER: There is going to be inconsistency in Social Work isn't there?

MIRANDA: Yes I said it just worries me but you know, but again this is the first time she has, so –

HEATHER: But also long term workers don't always have the same level of assessment skills you know it is all we do so those bits of our skills are more finely honed than our long term abilities. Long term workers aren't necessarily the best at assessing because they don't do it as frequently, not formal assessment where they are trying to prove something either for Conference, Court or for their Managers even because that just sounds bizarre.

MIRANDA: And that is another one at the Conference where you know I sat there and everyone was saying 'well yeah I think she should be given the opportunity to try again' and I just sat there and I said you know 'I want it noted that I do not agree with this in any way shape or form, you know I know Grandma cannot accommodate these children full time and I think it would be tragic that they would end up in foster care but I think that is the best thing for them and I do not think Sophie is evidencing this. You know we are talking about years this has gone on. You know the whole time I first came in contact with this family when I first moved to this caseload and she has been in and out, up and down her whole time, I said 'that's not for me evidencing that she can you know'.

HEATHER: But I think we can be snobs professionally and we can dismiss every other profession if it doesn't suit our view point and I think we are really very bad at dismissing Health Visitor's concerns actually and forgetting that that history is there. You know I am just thinking about a case I had where we had a very clear view of what was going on in the household. The Health Visitor didn't agree and it has come out 'well that is just the Health

Visitor who was stressing out' and you know whether that Health Visitor seemed stressy or not actually we –

MIRANDA: It is a concern isn't it yes.

HEATHER: Well and we do dismiss the years that you spend seeing a family and I think particularly now that your Service is so stretched and some families you don't see more than once or twice.

MIRANDA: Yes outside of the development checks yes.

HEATHER: Exactly and ... aren't even doing development checks at the minute because they have got no staff whatsoever or they feel that way.

MIRANDA: One I think!

HEATHER: Yes bless them, for the whole of ....

MIRANDA: One member of staff!

HEATHER: Yes exactly for the 80,000 population but I think we do dismiss that history, I think we are very quick to assume that we know best, very quick to and I think that is a problem.

One last question that I have got really is do you think that your professional identities create different value perspectives, is there something about being a Social Worker and being a Health Visitor that comes with a certain set of values?

HEATHER: I think Social Work, you know we talk about Social Work values, there is a very set sort of criteria isn't there of and set values that you study when you are at University that you always try and remember the list and hold on to but I think you know Social Work is supposed to be synonymous to ethics and values and being non-judgemental and non-discriminatory, which is difficult given the job that we do in Children's Services where it is sometimes draconian and punitive but we try and hold on to those values but I have to say I have never observed you MIRANDA to have any different values from us really?

MIRANDA: And I think bottom line even with clashings of personalities, with different feelings, I think our values very much are the same, I think we, regardless of what training path has brought you to which job you are currently sitting in, I think we very much are, the child is at the centre of everything we do so your values very much have to be roughly the same.

HEATHER: And I think that is what I meant earlier when we see, we often see Health Visitors asked the other, sort of the Health Social Workers if you like, you know I look at my colleagues in Adult Mental Health who are integrated teams and they are anything but and the Social Worker's identity is lost in a negative way often and you look at you know what you study about medical model versus the social model and how negative the medical model is and how great the social model is and what have you and then look at Health Visitors and actually I don't see any difference in how we approach families, I don't see any difference in our value base. I think if you integrated Social Workers and Health Visitors I could foresee us losing our identity but not necessarily in a negative way but just because we are both functioning in such a similar way that is my perspective yes.

MIRANDA: I think you know fundamentally what we do is very similar, it is just we are looking at it a little bit through different glasses and I don't think that is a bad thing, I think you need to have everybody, a different perspective otherwise you are only going to see what you see and I think that is where the clashing of personalities comes because people believe that their perception is right over everybody else's and it can't be and that is why I have to think of it as a puzzle because then it helps me remember that I am only one piece and just because I passionately believe that my perspective is right and I think these children are at risk and my Social Work colleagues might not, the puzzle for me just makes me remember that yes I am only a piece and I need to take into account of what other people are seeing because it is valuable in my judgement as well and some people are not so good at being able to value other people's perspectives.

HEATHER: Yes I was going to say as Professionals I think the values are very similar, I think as people we all have a different value set that we need to acknowledge and then accept how they impact on our work but yes yes I think you are absolutely right.

MIRANDA: You need to leave your own values and ethics at the door when you are dealing with other people's dynamics in the family home.

HEATHER: And if you have got any that you struggle to leave you just need to be aware of those don't you and you know I have heard you say and I have said it 'well this might just be my own personal view but have you considered that' but that is part again of communication you know full circle really. Communication and tossing things about when we have sort of seen a case together or come at it from different sides in that communication and that discussion, you see where maybe your personal judgements are impacting on your professional and you know it makes it really beneficial.

MIRANDA: And it is how I think you know my job has taught me that everybody parents the way they were parented and that doesn't mean I was parented correctly, I come with baggage, you know I was smacked you know and that probably, I will probably somewhere down the line that will come out and manifest itself in some issue, you know and no parent is right, there is no manual for parenting and you know sometimes we can be tough on parents when actually they have had a really tough childhood themselves and their blue print is crap and if their blue print is crap then how are we expecting them to parent at a standard that is alien to them, they are going to need a bigger package of care because you have got to alter their perception of what childhood should be and what is important to children because that has changed as well you know you get lots of parents saying 'well my mum said putting baby rice in the bottle is fine, it happened to me and I am okay'. Yes when that happened that probably was the right thing to do, I don't think your mother was wrong in doing that, we just know from years of research down the line that actually that is not a very sensible thing to do now because, in giving them the reason because, because you know the weaning age is always bloom 'in changing and it devalues us as Professionals because the Government you know the Department of Health will say it is now six months but actually they haven't said that, what they have said is 'it is between four and six months' and you know we are drive, drive, driving information to parents to then turn round two weeks later and say 'by the way it's changed' and for me that devalues the information I am giving. I always give a realistic view to parents and I won't preach six months weaning because the Department of Health didn't actually say that, it said the earliest four months and the latest being six months you know and how are we expecting parents to achieve targets when we are not being truthful in the way we deliver it.

If you are putting, if you are setting, you are leaving your values and ethics at the door, your own personal ones where do they come from? What are the standards, where do the standards in your work practice come from if you are setting aside the ones that you feel?

MIRANDA: For me the values and ethics I work from when I am in somebody's home are the Department of Health and World Health Organisation, they are the research evidence based stuff that says 'this is what children need to grow and develop' 'this is you know domestic abuse, this is how we know it affects children even if they are sleeping upstairs in bed and they can't hear anything, we know it impacts on children' and you know I think that is where my –

HEATHER: Yes I think if you focus on the child it is easier to follow, oh I don't know what the word is, but to have positive values and ethics with families, if you focus on the child's needs you stop yourself from sort of judging parents in a negative way or by your own standards, if you focus on the child's needs and the parent's answer to those needs rather than the parent, it helps you to look at everything in a more open minded way but I guess my view is you can't leave your own values and ethics at the door because they just don't come away, you know, so you just learn to acknowledge how they impact on what you are doing and what you are seeing.

MIRANDA: Right.

HEATHER: So for example I come from a household where a clean and tidy home was a reasonable standard but you know house proud is not something my mother would ever have admitted to and it is not something I would admit to, so I know that my expectations for what is a clean house and what is appropriate are very different from some of my colleagues, so that is where the 'good enough' really comes in. My questions would be again centring on the child. Will the state of that home impact on the child's health? Will the state of that home impact on the child's development? Like you were saying you know then you go to your theories, you go to your research, you go to your knowledge and skills that you have built over the years, your experience and you use that to make sure that your values stay where they should be and that you know they don't skew things and I guess you realise in other Professionals how much they can impact when you hear Police Officers saying to parents 'I am going to tell Social they will come and take your kids away'. You know and when you hear other –

MIRANDA: Because your home is dirty!

HEATHER: Well exactly or –

MIRANDA: Your children might be a bit grubby but you look at them and they are actually –

HEATHER: They are happy and fine and that is where the judgement balance comes in and it is all a balance and a reflection, you see I think this is why reflection is at the centre of everything because if you don't reflect on what you see how will you know what is informing your decisions and how will you know whether those decisions are right or not, you know. You need to be clear about why you think that, what your motivation is, what your agenda is and that is personal agenda as well as professional agenda. I think that is vital and I think if you see cases where things have gone horribly wrong, often it is because there has been a personal judgement or a personal value base has crept in somewhere with that reflection, so you know I have heard workers not check a baby because they are worried about waking it

because they know how it feels because they are new parents and obviously a question that comes up in my job all the time is 'do you have children of your own?' and I refuse to answer it because it is irrelevant because I know what a child needs, whether I have got children or not, and actually being a parent can either be a formative or skew your view in a negative way depending on your own experiences at the time so it, you need to focus on that child's needs, whether that parent can meet those needs and what the research tells us about the impact on that child in various situations. If you reflect on those first and foremost then hopefully your own personal judgements are managed within your decision-making but it is a constant value and we all have avoidant behaviour. At the house where I was held hostage I had serious misgivings about going to it but I thought it was just because it was late in the evening and I was tired, so you know personal instinct and values –

MIRANDA: Is a huge part of what we do, when you visit people's homes I think other Professionals down play our, GPs especially, you know 'I just have a feeling about this mum or this dad, you know when they next come in to see you could you just explore this?' And you know they are like 'well -' doctors want a very medical model so they want that 'well what have you seen bruises on the mum, have you seen bruises on the baby?' And you are like 'no everything seems okay but there is something not quite right in that house' because that's, we are in people's homes and I think we function on very non-verbal cues, you know you can read people. I think certainly because I am trained to look at children and read their behaviour into what that means you do it with adults as well, so you are kind of sitting there and mum might be telling you everything is fine and dandy but her body language is not telling you the same thing and you know that is really hard.

HEATHER: Yes and that self-awareness of why have you got that gut reaction, I think that is part of your values, you know it is an extended version of your value base and you know people will say 'oh it is not really gut reaction it is years of experience telling you' and yes wholeheartedly I would agree with that but sometimes you just don't like the person you know and it is being able to recognise the difference not just to keep ourselves safe but also to keep that child safe and when I say 'safe' I don't just mean safe from parents, I mean safe from us sometimes because sometimes you can see cases that have escalated all the way to Conference and you think what on earth!

MIRANDA: How did it get there?

HEATHER: Well and that is as abusive to a family as anything else, our involvement has an impact and not particularly positive, particularly at the beginning, it is very traumatic for all of them, we have got to have good reason for doing that and if it is personally driven because the worker is not recognising something, that is really damaging.

MIRANDA: Yes and I think that is where we are at an advantage like you were saying about going into the family, we can see, if we have been in there at the new birth visit we saw what that home looked like and then there was concerns six months down the line and we go into that same home and say 'actually do you know what this has deteriorated, that mum wasn't behaving like that when I saw it, something has gone wrong'.

HEATHER: Whereas we rush, we have to do the assessment and we either close it or we don't and then we go back a year later and somebody else entirely does an assessment and unless you get very clear follow-through you miss so much don't you in a way?

MIRANDA: Yes but that is where we need, the agencies need to trust and respect each other's opinions because it is not that we might be right but we might have that evidence to say 'actually do you know what, that house was always a little bit grubby and those older children always did look a little bit dirty and grubby but they have got a beautiful, I have always observed a beautiful bond attachment with mum, and dad you know is very hands on, he is very helpful' you know and we get that more now, Social Workers phoning up and saying 'do you know this family, have you had any input?' So you are more reassured and confident than when it goes somewhere that your piece of the puzzle has already been given.

HEATHER: And that is something they are trying to reiterate back in … but generally in Social Work are those background checks, those safeguarding checks with other agencies. I think it is something that's, particularly at the initial assessment stage, it is really easy for them to slip and they are really signing up in Norfolk on those and it is having a big impact I think and the joint protocol is also having an impact, it is testing boundaries isn't it the joint protocol because it is somebody you probably would never chose to work with but you have got no choice because you have to.

MIRANDA: I then, I think it is really good because you, and you need other people that you might, other Social Workers that you might never have worked with before.

HEATHER: And you form networks as well don't you?

MIRANDA: Yes so at least next time if they come, if they are the named Social Worker for a family, 'well I met them at the joint visit, I kind of know how they work'. So you know you can –

HEATHER: Yes and Conference is easier when you have done those visits as well which is why I think it was brought in wasn't it to make Conferences better?

MIRANDA: Yes because it is incredibly difficult to sit round a Conference table with Professionals that you have never met before and you have only got your little bit of the puzzle and you are very passionate about it to then say your bit. Whereas when Professionals have already started working very closely together, it's, I think when the Professionals are relaxed round the table it is easier for the parents to deal with the blows because they know it is joined up working, they know those Professionals have all spoken to one another, they have seen them visit together, they know they are all singing from the same hymn sheet, so when you deal them a blow you can back up your colleagues equally.

HEATHER: It gives them a very clear message doesn't it which they need yes.

MIRANDA: Yes yes.

Thank you and that has just been absolutely splendid. Is there anything else that either of you would like to say?

Both: I don't think so.

We have covered a lot of ground, if you are worried at all about anything that we talked about today then you know there are people within your agencies that are aware of my research and you can go and speak to, you can also make use of the Counselling Services that you both have within your own organisations and you can come back to me as it says in the protocol or you can, you know if you are unhappy with anything that I have done or

anything I have said then you can also speak to my Head of School or the Chair of Ethics Committee as well and their contact details are on the sheets that I have given you too, but thank you, thank you very much.

HEATHER: You are welcome.

MIRANDA: Was it okay?

HEATHER: It is a good excuse for us just to –

MIRANDA: To have a laugh really, we never have much of an excuse and life is so busy now we don't get to catch up very often so.

Were you surprised by the things that you talked about?

MIRANDA: I think it has just reaffirmed for me that we are from, you know we are one and the same although we are employed and paid by different agencies that you know it is what I already knew.

HEATHER: Yes the same here absolutely. Yes yes, this was pretty natural wasn't it, I can talk to you about our, yes because we have always, and it is over many years now actually that we have got that working relationship, it is not new so yes yes I guess in that sense.

I am going to have to ask you HEATHER because you mentioned it several times about you being taken hostage and what happened?

MIRANDA: It clearly turned out okay because she is here!

HEATHER: I'm here even though they had a pond that they could bury me in, it is a new born baby that I was dealing with, mum was still in hospital with the baby, this was Nita's case –

MIRANDA: Oh yes.

HEATHER: You know the one I mean? And mum not very well mentally, I was worried about her cognitive ability but we knew hardly anything about her history so my Manager has helpfully said 'oh could you just go and see grandparents on the way home' because mum is in … , obviously we are in … and the grandparents are outside …. in the middle of nowhere, so it made more sense to see them on the way home than to come out the next day and we were very clear that baby wasn't safe to go home with mum because of her presentation. I rang grandparents before I went up to mum, I was going up to mum to ask her to sign a written agreement to say she shouldn't remove baby from the Ward and they would call the Police if she tried, you know, standard agreement. I phoned up first to say 'can I come and see you when I have finished with your daughter?' She said 'no, no, no' she was very belligerent,' I hate Social Workers' she said something about once when she was working somewhere a child had an accident and a Social Worker did something, I wasn't paying a great deal of attention if I am really honest –

MIRANDA: Because you just wanted to get out and done.

HEATHER: Well yes I just wanted to get up and deal with mother and deal with her, well when I saw her I thought you know face to face she will be fine you know as you do, face to face she will be fine, it is very smug isn't it! And so I went up to see this mother and I said 'I am going to see your parents' and she looked really worried and I should have known then, I had already been dreading it because grandmother was very belligerent but I actually

thought the biggest risk was being stuck there for hours. I didn't get to them until 7 o'clock that night so I had been at work since 7 in the morning so I was shattered and I had a long fifty mile drive. So I had rung my husband and said 'can you ring me at quarter to eight if you have not heard from me just because I think this is going to go on forever, I think it is going to be a long one'.

MIRANDA: You needed an excuse out yes.

HEATHER: Exactly and, but of course I can't tell him where I am or anything, nobody knew where I was, the Assistant Team Manager knew I was going to grandparents but she wasn't at work the next day, she was done for the evening so yes it is like the usual situation where you are on your own, nobody knows where you are, you are in the middle of nowhere, nobody can find your car, finally found this address and it's in the middle of a single track lane, it's behind some barns, so my car was out of sight, in fact the entrance to the place was out of sight. Got there, they were really aggressive, I should have known at the door grandmother said 'call me …, my name is not Jennifer my name is …' I should have just turned tail and ran at that point but I didn't. I went in, very very aggressive, dad or granddad was and really going for it, hitting things, he was very very angry, she was very angry shouting at me and what have you 'you are saying my daughter is insane' you are saying this, you are saying that. They sat me down and stood over me, they sat me on this low sofa and stood over me whilst answering and getting very very angry and I stayed very calm and quiet and was kind of saying 'you know Sandra your daughter I am not saying when she is back home I am not saying she will hurt it, she is just showing some risk factors that we know can be a problem after birth you have heard of post natal depression?' and just trying to keep it because at that point I felt we were not getting far at all –

MIRANDA: And you need to just say one –

HEATHER: Well and I was under orders to see if this was a suitable place for mother and child to go, so I am still trying to work through that because I know what my boss is like, anything but foster care and thinking 'this isn't going well.' Well then she said 'and will you come and visit if my daughter and grandchild come here?' 'Well yes you have just accused us of not knowing your daughter, I agree we don't know her that is why we are not sure that she can take baby home, so we would have to visit where she lives in order to get to know her to see if she is safe' so trying positives, you know 'we want her to go home, it is our mandate to keep families together' all of that. 'Well I shall get an injunction if you don't, if you want to come and see the children. I am not going to let you see this child rar rar rar. You are saying she is insane, you are going to take her child away and she is never going to see it again, she will kill herself if you take the child'. I mean really aggressive and I think the injunction was the final straw and I said 'I don't think we are getting anywhere, I think I will leave that conversation there tonight and I will call you tomorrow' at which point they came forward and starting shouting at me and rare rar rar you are not doing f*** f***f*** Awful! So I stood up and I said 'I'm sorry but you are intimidating me, I am feeling quite scared of your behaviour, I am going to go now'. 'You are not leaving, we are not letting you leave this f***ing house' and as I went towards the door they ran to the door and blocked my path and so I said, I sat down again 'alright' trying to de-escalate again 'alright' and got my phone out and then grandmother, I don't know what it was whether she could see it on my face but something told her she had gone too far and she calmed down just enough to sit between me and the door and she started to speak more calmly. He was still there and storming around and hitting things with his fist but she was a little bit calmer and she started to say

about you know well it is just this and it is just that and you really can't see the child and that was at the point where I was saying 'I know; I understand'

MIRANDA: And just do a little bit of –

HEATHER: Yes well I just said, yes I try not to be too dishonest and too but I thought if I challenge anything that she is saying even though I really should, I am not getting out of here. So it took about another ten or fifteen minutes but she calmed down sufficiently, she told him to back off a couple of times, he was still swearing like a good'un but he wasn't quite, he was like this most of the visit, ready and that was what, I think that was his body language as much as his aggression that unnerved me and I managed to get, it was an effort to get to the front door which I thought, although she stood in front of me and then he said 'you have got a long journey would you like a cup of tea before you go?' 'No, no that's fine'.

MIRANDA: I really don't want to stay any longer!

HEATHER: And while this was all going on the heavens opened there was a massive thunderstorm this is .... Street and it really is an awful rural area isn't it, so there were inches of water on all the roads and pouring with rain.

MIRANDA: You didn't care as long as you got home to be honest!

HEATHER: Exactly and she said 'oh I will walk you out to your car with an umbrella' 'No please don't!'

MIRANDA: Well that almost, that evidences without you having to ask any questions, evidences the normalised behaviour that aggression is in that household.

HEATHER: Well it got even worse because as she got to the door and I was very grateful she waited until then to tell me, is, she got to my car she wasn't still going to let me to go home and she was between me and the driveway turning round so I still couldn't get away and she said 'you have removed my children, I had three in three years when I was twenty one'. I said 'no we wouldn't not just for that, that is nothing' she said if you know how aggressive my husband is, it is like 'oh shit!'

MIRANDA: I haven't seen that no! But that is almost what mum had, I think mum had kind of, because Nita had already ruled out the grandparents in her mind could be considered for –

HEATHER: Well the Guardian now thinks that I should meet with them so that they can apologise and we should reassess them.

MIRANDA: But I mean the fact that they thought it was appropriate to behave like that in the beginning.

HEATHER: In my career I have been scared exactly three times, the first time I was newly qualified and I was with someone Bi Polar who was psychotic and I was sent on my own into the household to say that we need to take the children away but actually with psychosis you know I guess from a Mental Health position –

MIRANDA: You have a kind of –

HEATHER: If you work within their sense of reality you can talk them down quite easily and you know she smashed a frame at my feet but she got over it and was fine and the next time

was when a client went for me, she didn't injure me but she went to assault me and there was no warning, we had done everything right, there was no warning she still flew for me and this time they really scared me, there was no reason in those two people and there is no reason in their daughter which is why we are so concerned for her.

MIRANDA: Which you can sometimes see why she is how the way she is, you almost feel a little bit, have to feel sorry for the girl because again just like a blue print she is, her learned behaviour –

HEATHER: Her learned behaviour and the damage yes.

What is your Manager saying about this case, what has your Manager done about this?

HEATHER: He laughed at me and told me about the time when one of his clients, err not one of his clients, one of his workers was taken hostage and the mother wanted more contact and he said 'no' so he rang the Police.

MIRANDA: I think that sort of thing is very normalised in our professionals in general.

HEATHER: I think yes and at the beginning of the day he was still very much saying 'it is a real shame because if they hadn't behaved like this, the mother and baby could go there'. Are you sure?

MIRANDA: You see I am actually pleased they behaved this way because that has evidenced that they are not normal civilised human-beings.

HEATHER: But it is pretty normal and my Assistant Team Manager, bless her the one that was on leave the next day, she was great. I rang her on my way out, so on my way home from the visit, I had rung my husband to say 'you will never guess what happened but' and –

MIRANDA: And where was your phone call?!!

HEATHER: Well you are still running on adrenaline aren't you at that point so you are pretty buoyant and then I said 'I will just ring HEATHER, we did say we would just text to let her know that I was done but I will just ring her' and I was really grateful, she was great, she was really great. No my boss was pretty amused really, not in an awful way, he was just –

MIRANDA: But I think humour in our job plays a part of counselling almost, so I think people sometimes use humour as a way of counselling each other.

HEATHER: Yes and I think that is fair, it was the joke of the day in the office but not in an uncaring way. He has been great around this case and the team have been great and actually now I have got another one that is very risky because I have got a guy who tried to burn his last family alive and he has just moved in with a mother and three very small children, that one was Judy's, that was the one I was very short about and you know my boss has been very much 'you need to take someone with you and make sure you are safe' and my colleagues have rallied and they have all been quite protective at the minute which it is really not a protective team so there is an acknowledgement but it is power for the course isn't it, it is the type of thing we have to deal with in our job and I got out of it, I think it would have been very difficult if I had not got out of it.

MIRANDA: I think your communication skills got you out of it in the end.

HEATHER: Yes it is communication skills for getting out of it.

MIRANDA: It has only ever happened to me once or twice and both of those occasions were when I worked in ... and they weren't expected, again it is when you challenge people, I told a family that I was concerned and you get –

Appendix 4 Case Study

Mandy (27) and Steve (28) have been a couple for 8 years. They live together in local authority housing in a large town. Both are of white British heritage, and neither have any meaningful support from their birth families. Neither Steve nor Mandy are employed at this time.

Mandy has a moderate learning difficulty. She is five months pregnant, and this will be her third child with Steve. Mandy was sexually abused by her now deceased father throughout her childhood and didn't disclose this until after she left home at 19. This led to a serious falling out with her mother, who did not believe her. Mandy has a younger sister with whom she has not spoken for years, but no other relatives that she knows of. Mandy has a learning disability social worker but has little contact with her.

Steve has a history of mental health difficulties, including depression and anxiety. Steve has also been suspected of fabricating illness as a way of attracting attention to himself. He was brought up by his dad and step mother, Martha, from the age of 6 when his mum died. His dad passed away when Steve was 10, and he remained in the care of his step mother until he left home at 18.

Two previous children, Harriet and Sam, were removed from the couple's care when they were one and three years of age respectively, due to neglect. Problems included, extremely poor hygiene, frequent unexplained injuries to Sam and concern about Harriet's failure to thrive. Both are now placed with Steve's step mother under a residence order. Contact with the children is infrequent, as Steve and Mandy often cancel at the last moment. Harriet and Sam seem to be thriving in Martha's care.

The unborn child has been referred to Children's Services for a pre-birth assessment by Mandy's GP on the basis of the history with the previous children. During the assessment Mandy showed excitement about the new baby and repeatedly said that she wanted to parent her. Steve was less sure and seemed depressed at the thought of being a parent again. At a child protection conference, it was decided that the unborn baby was at risk of significant harm through neglect and should be subject to a protection plan.

What do you think? Do you agree with the case proposal?

Note: For the purposes of this study it should be assumed that the 'service user' is 'the unborn child'.

It is proposed that Children's Services should remove the new baby soon after birth