A Discursive Study of how Mental Health Social Workers Constructed their Professional Selves within the Context of National Health Service Mental Health Services

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Abstract

Since the 1990s there have been continued drives in England to integrate National Health Services and Local Authorities' social care within a single mental health service, with the aim of bringing about improvements in health and social care (Local Government Association *et al.*, 2016). This is underpinned by the belief that through bringing the different professional health (such as psychiatrists and mental health nurses) and social care disciplines together, people in need will have a single point of access to a range of skills and knowledge, that no one system could deliver alone (Cooper, 2017). However, the very unique professional approaches that have been stated as the reason to place social workers in NHS Mental Health Services have been the ones that mental health social workers have struggled to hold onto in this setting (Allen *et al.*, 2016).

This is a thesis of how mental health social workers constructed a professional self within the context of the NHS mental health services. I used a Foucauldian approach and the notion that professional identity is a socially constructed sense of self, produced from discourses, subject positions and a process of subjectification. Twelve social workers were interviewed; seven mental health social workers and five social workers who held positions as managers or educationalists. I asked social workers questions about their professional identity, their answers provided a rich source of 'talk' that I could analyse using Parker's steps to discourse analysis. The findings discuss the nature of social work as a profession, generic and specialist social work, and suggests a typology of subject positions drawn from the mental health social workers' discourses. These findings provide a useful resource to support critical social work practice, both as an example of how Foucauldian theory and concepts can be a rich toolbox for understanding practice in complex settings, and through the use of the typology of subject positions as a source to prompt self-reflection for mental health social workers' practice.

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List of abbreviations used in this thesis

ADASS	Association of Directors of Adult Social Services
AMHP	Approved Mental Health Professional
APPGSW	All Party Parliamentary Group on Social Work
BASW	British Association of Social Workers
CBT	Cognitive Behavioural Therapy
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
DoH	Department of Health
Ethos	E-THesis Online Service
HCPC	Health and Care Professions Council
LA	Local Authority
LGA	Local Government Association
MHA	Mental Health Act
NELSON	Northampton Electronic Library Search ONline
NHS	National Health Service
NHS-MHS	National Health Service Mental Health Service
NICE	The National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
NSFMH	National Service Framework for Mental Health
MHSW	Mental Health Social Worker
SCIE	Social Care Institute for Excellence
SCMH	Sainsbury Centre for Mental Health

Chapter 1 Introduction

1.1 Mental health social workers and integration in NHS mental health services

In England since the 1990s there have been continued drives to integrate National Health Services (NHS) and Local Authorities' (LA) social care services to bring about improvements in health and social care (Bogg, 2008; Local Government Aassociation (LGA) *et al.*, 2016). This has been underpinned by the belief that through bringing the different professional health and social care disciplines together within multi-disciplinary teams, people in need will have a single access point to a comprehensive range of skills and knowledge, that no one system could deliver alone (Cooper, 2017). Also, driving integration is the conviction that integrated services are the most efficient way to provide care, and to address the challenges of economic austerity and increasing demand that are impacting on both systems. Within this vision, social workers are essential to integration, to bring social models and social care alongside medical models and treatment (Romeo, 2016). In adult mental health care, the move to greater integration was furthered by legal frameworks under the Health Act 1999 (Section 31) and the National Health Service Act 2006 (Section 75); these saw many LAs delegate their social care duties and second their mental health social workers (MHSW) to NHS mental health services (NHS-MHS) to work in multi-disciplinary teams.

As Head of Mental Health for a LA with responsibility for setting out and gaining a current agreement for the integration of social care and MHSWs within the local NHS-MHS, it was difficult to reconcile the policy vision of integration with what I was experiencing in practice. I found social care for people with mental health problems as an unclear concept, as this function had come to mean something different to that of other adult social care practices. Mental health social care had evolved within NHS-MHS separately to the other LA adult social care and I had difficulty recognising the model of social care delivered by the LA for adults under the Care Act 2014, with what the social workers were describing as their work within the NHS services. Policy states that wherever they are employed, social workers should ensure people have support to access the statutory social care and social work services they are entitled to (Allen *et al.*, 2016). The Five Year Forward View for Mental Health launched in 2016 by the Independent Taskforce for NHS England called for the Department of Health (DoH) to support the expansion of qualifying programmes for social workers, citing the role of social workers as ensuring the workforce readiness to provide high quality social work services in mental health. However, when I asked for a description of the delivery model for social care and social care practice within the integrated services, the MHSWs struggled to answer.

Attention to statutory duties can be diminished within integrated services which are driven by NHS performance drivers (Allen *et al.*, 2016). I had read that 'knowledge and skills that have no name cannot be integrated' and how little concepts have been defined that are used every day in social work (Trevithick, 2012, p.136), and wondered how could I discuss the integration of social care with health when I could not

articulate a congruent understanding of what mental health social work was, and what the seconded professional MHSWs were contributing to the multi-disciplinary team from a social care perspective. I was also aware of concerns raised by Tew and Anderson (2004) that in the context of multi-disciplinary mental health teams the nature of the professional education of social workers can create an imbalance in relation to their peers. Unlike mental health nurses who complete specialist mental health training to qualify and register as a Mental Health Nurse, social workers may receive little or no mental health training on their professional programmes, with mental health placements being their only learning experience. This can leave them ill prepared to take up positions as professional equals, and more vulnerable to historic discourses that situate social workers as subordinate to the *real* work of doctors and nurses (Tew & Anderson, 2004).

These were the origins of my research question and motivation for completing this study, as I wanted to develop a way of discussing what professional MHSW meant, drawn from those practicing within NHS mental health frontline services. I wanted to make a connection between national policies that drive the practice of LA managers in posts similar to mine (Department of Health (DoH), 2015) with accounts of MHSWs practicing in NHS-MHS. Drawing from a Foucauldian theoretical framework (O'Farrell, 2005) this thesis takes the position that what 'MHSW' means is discursively formed and socially constructed. I have used Foucault's notion that 'identity' is the product of discourses *and* a process of subjectification and subjectivity. Subjectification is referring to how a person transforms themselves into the subject of a particular discourse, and subjectivity as the process of the person constructing 'identities' at a given moment drawing from different discourses and social practices (Kelly, 2013) . The concepts of discourse, subject positions and subjectivities have been used to explore how MHSWs working in NHS mental health settings constructed their professional selves in interviews about their professional identities.

1.2 The social worker, constituting *effective* NHS mental health services

The value of social workers within the delivery of NHS-MHS to adults with mental health problems has been repeatedly stated since the New Labour Government's National Service Framework for Mental Health (NSFMH) required social workers to be core members to produce *effective* community mental health teams and NHS-MHS in 1999 (DoH, 1999; DoH, 2001; DoH, 2002; Godden *et al*, 2010; Allen, 2014; Allen, *et al.,* 2016; All Party Political Group on Social Work (APPGSW), 2016). What was said to be unique about MHSWs was their commitment to:

> …empower service users and carers through values based and evidence based interventions within a social model and understanding of mental distress, emphasising choice, dignity and worth, equality, respect and social justice grounded in anti-oppressive practice (DoH, 2007a, p.112).

Social workers were expected to act as change agents in achieving the overall aim of the NSFMH initiative of moving NHS-MHS from traditional practice perspectives based on medical models to modern capable and competency based teams (DoH, 1999). In parallel with the new policies in mental health, the New Labour Government was developing its social inclusion initiative launched with its cross departmental Social Exclusion Unit Report *Mental Health and Social Exclusion* published in 2004 (Office of the Deputy Prime Minister (ODPM), 2004). The skills that social workers could bring into mental health services were intended to increase the teams' capacity to practice from understandings of mental illness that included social concepts – social models, social determinants, social interventions, social inclusion and social capital (Duggan *et al.,* 2002). As the NSFMH's *New Ways of Working* (2007b) guidance stated, social workers were integrated into multi-disciplinary teams to be '…major culture carriers for a socially inclusive perspective and be valued… for this' (DoH, 2007b, p.24).

Bringing professional social worker practices into NHS-MHS has not been an easy task, and the current conservative Government recently relaunched social work in mental health through its initiative Social Work for Better Mental Health (DoH, 2016), to reiterate the value of social workers to people who have mental health problems and what social workers' skills in mental health were. The strategic statement constituted the MHSW skills brought to the NHS as advanced relationship skills, skills in tackling stigma and discrimination, legal and statutory knowledge, skills in protecting people from harm, working holistically and using strengths based approaches (Allen *et al*., 2016, p.5).

In addition to the relaunch initiative by the Government in January 2016 (DoH, 2016), in September of the same year an All Party Parliamentary Group on Social Work (APPGSW) published the results of its inquiry into adult mental health services and its recommendations to the conservative Government. The report introduced the findings by describing how the inquiry had revealed 'the true scale of the crumbling mental health services' (APPGSW, 2016, p.2), that mental health problems are rising, that there are fatal consequences of a mental health system that is letting people down and 'too many deaths could and should have been prevented'. It is in this context that the report *specifically* emphasises the role that social workers can play in mental health care and resonated with the 1999 NSFMH, in providing a new way forward for mental health services with the old models of care being no longer fit for purpose. The report describes the medical model as only seeing people as patients, not as individuals, recognising only the diagnosis and not the person and as 'overly dependent on budget restraints and workplace targets' (APPGSW, 2016, p.2). Again, MHSW comes to mean a way of changing a mental health service through challenging its medical model culture. This meaning of MHSW produces the offer of a possible better future, where the MHSW provides a counterbalance to a dehumanising medical approach and potentially able to prevent suicides and reduce fatalities. However, the very skills and approaches that have been stated as the reason to place social workers in NHS-MHS have been the ones social workers have struggled to hold onto in this setting (Allen *et al.*, 2016).

1.3 Constituting 'mental health social worker' within NHS mental health services

Working as a professional social worker within NHS-MHS had been described prior to the launch of the NSFMH as problematic (Onyett *et al.,* 1994), and in the year the NSFMH was launched Peck and Norman (1999) published a study described as a response to the 'poor state of inter-professional working in adult community mental health services' (Peck & Norman, 1999, p.231). They reported on meetings held with professionals who were members of community mental health teams (CMHTs) and discussed their perceptions of their own and other disciplines. There were 12 social workers included in the study. The *social workers story* was one of being under *siege:*

> The creative tension, which … the inclusion of social workers was meant to bring to the CMHT, is often viewed as disruptive rather than creative. Tensions between disciplines easily become conflicts between them... Social workers, usually outnumbered by health …colleagues, are obliged to defend their position or compromise in ways that threaten to undermine the social work culture (Peck & Norman, 1999, p.237).

The concern was that 'MHSW' would come to mean 'mental health worker', interchangeable with Community Psychiatric Nurse (CPN), a social worker with a professional qualification but socialised into 'being a pseudo-CPN' (Peck & Norman, 1999, p.237). In the APPGSW report (2016) 17 years on, the sort of MHSW possible in services places the social workers very much in this role. This report describes social workers as professionals who are 'deployed' (APPGSW, 2016, p 4), not for their professional social worker skills, but to act in more limited roles such as care coordinators under the Care Programme Approach (DoH, 1990).

In recently published research into MHSWs who were Approved Mental Health Professionals within NHS-MHS (Morriss, 2016), MHSW means a professional whose skills are invisible within NHS multi-disciplinary teams, skills which are unarticulated and undefined within NHS-MHS, and where MHSW comes to mean a worker who fills the gaps left by other professionals. Within NHS-MHS, although policy rhetoric has reiterated the value of social workers to people who have mental health problems and the importance of cultural and professional skills and knowledges they could bring to multi-disciplinary teams, in practice achieving this vision has remained problematic.

1.4 Material events, practice issues and constructed selves

When I was Head of Mental Health for a LA in England, (also see Section 1.1), I was responsible for the MHSWs in the local NHS-MHS who had been seconded from the LA under a Section 75 Agreement (National Health Service Act, (Section 75), 2006). The agreement enabled the LA to delegate its social care duties for people with mental health problems, such as social care assessments and provision of social care, to the NHS-MHS. This was intended to enable the delivery of an integrated service to enable a person with mental health needs to access and receive both NHS and LA services at the same time and through one process. The

LA employed me because of my years of mental health practice and senior management experience. I was not a social worker; my professional background was as a mental health nurse and I had worked as a community psychiatric nurse (CPN) within a NHS-MHS multi-disciplinary team. I had also held a post previously as an operational manager for integrated NHS and LA acute and specialist mental health services. It was made clear that I was recruited because the LA struggled to understand the NHS mental health system, what the specialism of MHSW meant in practice, and were unclear how the MHSWs were or should be delivering social care duties within the NHS services. In this situation, I found the matters of MHSWs constructing a professional self had importance beyond a theoretical definition, as it took place within a day to day practice context with the real events of people with mental health problems, such as becoming homeless, suicide and having a child taken into care. I noticed that the struggle to construct a professional self affected the nature of the relationship the MHSWs had with a person using the services, what is constituted as 'the problem' and what were practice priorities.

It is not unusual for MHSWs to describe their experience of being employed by a LA but working within NHS-MHS as being like being caught 'between a rock and a hard place' (Morriss, 2016, p.7) with the dual pressures of both organisations' competing cultures, priorities and systems. MHSWs have reported feeling abandoned, adrift and unsupported by their LA employers (Bailey & Liyanage, 2012; Morriss, 2016). When I met the MHSWs individually and in MHSW professional forums, I became aware of their eagerness to debate their role and responsibilities within the NHS-MHS. I found conversations sometimes contradictory, as I heard MHSWs ask for closer links to me as Head of Mental Health and the LA so they were not overlooked by the LA. I also heard they wanted to distance themselves as MHSWs from the LA and the LA's adult social care services because they believed the MHSW role to be unique and different to other adult social care roles. Similarly, I heard that working in the NHS-MHS service impacted negatively on them as professional social workers and the environment was medically dominated, and I heard that it was really important to be within the NHS-MHS to practice as a MHSW. Through this I perceived MHSWs as constantly embattled professionals, as they tried to build closer relationships and, at the same time, distance themselves from the LA and the NHS-MHS. When I asked what would make a difference, what needed to change, their answers suggested a sense of fatigue related to the energy used to sustain a MHSW professional self in this context. This was, therefore, not a situation where I could articulate a coherent and salient position for MHSWs within the NHS-MHS as it seemed to be a professional self constituted within debate and flux. I had difficulty articulating within the discourses available what MHSW was locally and what MHSWs did within NHS-MHS. I found it easier to draw on discourses of what MHSWs were not and did not do (e.g. they did not work as care managers, like other LA's adult social care social workers, and in relation to the NHS-MHS, they were not health workers such as nurses, there to complete clinical tasks). This reflected literature which produced a MHSW as a professional that struggled to say what it was in the context of NHS services (Blinkhorn, 2004) or one that could not be articulated (Morriss, 2014).

In Sections 1.1 and 1.2, I argued that placing social workers within NHS-MHS was to benefit people with mental health problems by providing access to a broader understanding of mental health than that of the medical model and NHS system view alone. However, in Section 1.3 I have suggested rather than acting as the cultural change agent intended and providing broader access, MHSWs have been reconstructed within NHS-MHS. Section 1.4 has placed the debates of what constitutes MHSWs' professional selves and a profession struggling to establish this in an NHS-MHS in the context of its practical impact on material events. I have also been aware of continued calls for research to take a central role in the development and improvement of social work and social practice (Romeo, 2016).

I recognise my position in this research as insider and outsider (Corbin-Dwyer & Buckle, 2009). I was insider from the perspective of my employment by a LA, in a role as Head of Mental Health, and as a mental health professional with experience of in working in NHS-MHS. I was also an outsider as I was not a social worker (Kanuha, 2000). Considering the nature of integrated services as multi-disciplinary and the importance of health colleagues recognising the value of MHSWs, I felt uniquely placed in completing research into the complexities outlined above with the intention that it benefitted MHSWs practice, and also would make a useful contribution to those concerned with the integration of health and social care in NHS-MHS. I discuss my positionality as researcher in Sections 4.13 and 4.14.

1.5 The research aims and question

Through this research process, I aimed to provide a new understanding of these complex issues and new knowledge that could be used as a research based resource for critically reflexive MHSW practice, in professional supervision, training and education programmes for social workers working in NHS-MHS. Based on the arguments I set the research question for this study as:

> What discourses do MHSWs draw from to construct their professional selves in the context of (adult) NHS-MHS, and what are the implications for the professional self of the subjectivities and subject positions possible within these discourses?

The intentions and aims of this study are:

- To provide a discursive understanding of MHSWs professional selves in NHS-MHS
- To illuminate the complexities of constructing a MHSW professional self within NHS-MHS by using discourse analysis based on Foucauldian principles (O'Farrell, 2005) and Parker's steps to discourse analysis (Parker, 1992)
- To draw an understanding from asking social workers directly about their professional identity
- To suggest the typology of subject positions that were possible for MHSWs within NHS-MHS

Heron (2005) argues that analysis of 'one's subjectivity and subject positions' is a valuable tool for self - reflection in critical social work practice (Heron, 2005, p.341). My contention was that by understanding what discourses, subjectivities and subject positions professional MHSWs drew from when constructing their professional selves I would produce:

- A practical researched resource for self-reflection in critical MHSW practice
- A valuable contribution to the knowledge underpinning MHSW practice
- Offer new knowledge to discourses of MHSWs in NHS-MHS

I considered this particularly of value at a time when morale indicators that have shown high emotional exhaustion among social workers in mental health services (Johnson *et al*., 2012), and where research has linked emotional exhaustion with issues of social workers' professional identity (Geng *et al.,* 2011).

1.6 Overview of the thesis

In Chapter 1, I have set out the rationale and background to the research question, and purpose of the research. In Chapter 2, I set out in more detail the theoretical approach underpinning my engagement with the literature in the field (research, reports and policy documents) and to the analysis of the interviews that I conducted with the social workers. The intention of this chapter is to clarify how a Foucauldian approach has been understood and where it positions the researcher in relation to the area of study. Chapter 3 sets out the analysis of the literature first in relation to the production of 'professional social worker' then in relation to the construction of MHSW within the context of NHS mental health settings. These two constructs (social worker and MHSW) both offer discourses, subject positions and subjectivities relevant to the production of a professional self within NHS-MHS. Chapter 4 provides information on how the theoretical approach was applied and how I completed the research process. It draws out the particular issues and challenges I faced in this approach and how I addressed them within the research process. The analysis of the social worker talk in relation to construction of a professional social worker self is presented in Chapter 5. I begin this with a consideration of the self as 'social worker', before exploring the construction of the 'self' as 'MHSW'. The talk from social workers who were managers and educators was included in this analysis alongside the talk of frontline MHSWs. Chapter 5 concludes with the typology of subject positions drawn from the analysis. As part of the analysis in Chapter 5, I have included some discussion of the points as they arose. I return to focus on discussion in Chapter 6, and link the analysis to implications, recommendations and applications for MHSWs' practice. Chapter 6 also clarifies the context of the discussion, methodological issues and areas that would be useful to consider for future research.

Chapter 2 Theoretical approach to understanding and analysis

2.1 Introduction

In developing an understanding of how MHSWs constructed their professional selves within NHS-MHS, this research offers a contribution to social discourses of mental health and a research based resource for reflexive practice, supervision and training programmes for social workers intending to work in mental health. Due to the complex nature of the MHSW construct set out in Chapter 1 and its relevance to the production of a MHSW subject, I needed to take an approach that could:

i. incorporate a wide range of perspectives, such as political, professional and bio-medical
ii. tolerate and include any conflicting logics present within the social workers' talk when speaking of their professional selves
iii. be recognised as relevant to frameworks of social work practice (Healey, 2005; Fook, 2012)

I took a social constructionist postmodernist stance on meaning and being (Crotty, 1998), particularly focusing on the *ways* in which professional selves were socially constructed (Rose, 1999). I did not assume that a definitive MHSW self existed; the purpose of the research was to explore what social worker subjectivities and subject positions were possible within meanings, where those meanings came from and how meanings shifted in constructing the professional self (Crotty, 1998).

I took a discursive position which enabled me to actively engage in these elements, and used Foucauldian principles (Rabinow, 1984; Chambon *et al.,* 1999; O'Farrell, 2005). My understanding of discourse analysis was substantially based on Parker's work (Parker, 1992; Burman & Parker, 1993; Parker *et al.*, 1995). I considered the concepts of 'subject', 'subjectivity' and 'subject positions' were valuable for addressing the research question. I developed my theoretical understanding of these concepts by drawing from critiques by Henriques *et al.* (1998), Rose (1999) and Davies & Harré (1990). This theoretical basis provided me with a rich and sufficiently stable framework to approach the research question. The remainder of this chapter explores these concepts further (see Section 4.11 for a discussion of how these were applied through the application of discourse analysis).

2.2 The relationship to material events

In this thesis, I have assumed that social work as a practice is constituted at the interface between 'material events' (like human death and injury), institutional realities (like 'The State', the family, and the NHS) and ideological positionings. I do not dispute the material world implications of each of these, but their meanings are constituted in language and social practices. Although Garrity argued that accepting a material reality is

incompatible with Foucault's position of the constituted object (Garrity, 2010), Mills argues that there has been substantial and *futile* debate on whether Foucault denied the existence of the real, and suggests the use of Laclau and Mouffe's explanation of the relationship between social construction and material reality (Mills, 2004). This moves away from a placing of realism vs idealism as an artificial duality. Laclau and Mouffe reason:

> An earthquake or the falling of a brick is an event that certainly exists, in the sense it occurs here and now, independently of my will. But whether their specificity as objects is constructed in terms of 'natural phenomena' or 'expressions of the wrath of God' depends upon the structuring of the discursive field (Laclau & Mouffe, 1985, p.108).

I was concerned that if Foucault's understanding of the real was read as a product of discursive processes, and that the real could only be known through an analysis of structuring discourses (Foucault, 1969), I would be seen as denying material phenomena such as suicide, or any ontological reality in MHSWs practice. Although I have not focused on social workers' engagement with materially real events in this research, I did not want to take an approach that appeared to deny that any existed. I found Foucault's position expressed in the quote blow, addressed my concern as it acknowledged the existence of real things and clarified the relationship between these and the research approach:

> For when I say I am studying the "problematization" of madness, crime or sexuality, it is not a way of denying the reality of such phenomena. On the contrary, I have tried to show it was precisely some real existence in the world which was the target of social regulation at a given moment. The question I raise is this one: How and why were different things in the world gathered together, analysed, and treated, as for example, "mental illness"? … For I think there is a relation between the thing which is problematized and the process of problematization. The problematization is an "answer" to the concrete situation which is real. (Foucault, 1983, p.171).

Therefore, in this research I have focused on the how and why the phenomenon of MHSWs in NHS-MHS has come to be constructed as problematic, without denying the existence of material realities in MHSWs' practice.

2.3 The Foucauldian principles underpinning this research

I have drawn my research assumptions from a range of Foucault's writings related to the nature of truths, knowledges and methodological issues. There was not a discrete, unitary, or singular Foucauldian method to apply (Hook, 2001) and Foucault stressed that his approach was not a single system of rigid rules but that it was a way of research thinking to illuminate new understandings of a chosen subject (Foucault, 1978). During his life time, Foucault's approach was different for different studies. Foucault was clear that his propositions were not to be seen as 'dogmatic assertions' (Foucault, 1978, p. 224), and theorists have used Foucault's work to develop arguments and debates underpinning contemporary discourse analysis (Parker, 2003), and understanding of the concepts of subject and subjectivities (Henriques *et al.*, 1998; Rose, 1999).

Foucault's approach to research was as an exercise to disrupt taken for granted truths and knowledges within institutions and disciplines, and to invite readers to understand the 'real' in ways that questioned what seemed to be natural and automatic understandings (Foucault, 1961; Foucault, 1977). Although stated by Foucault in 1978, the following quotes have resonance with the circumstances from which my research question emerged. The arguments, rationales and explanations set out in national documents constituting 'MHSW' and transformations of NHS-MHS, were remote from the material events and the social constructs possible found in the talk of practicing MHSWs. Foucault asserts 'The only important problem is what happens on the ground' (Foucault 1978, p.235). Also:

> The problem you see is for the subject who acts – the subject of action through which the real is transformed, it won't be because a plan of reform has found its way into the heads of the social workers; it will be because those who have a stake in that reality, all those people have come into collision with each other and themselves, run into dead ends, problems, impossibilities, been through conflicts and confrontations – when critique has been played out in the real, not when transformers have realized their ideas (Foucault, 1978, p.236).

This thesis has taken a position closer to *those who have a stake in reality* by drawing meanings and truths of what constructs the MHSW subject from the discourses of MHSWs working in NHS-MHS, in contrast to drawing meanings from professional and policy rhetoric. By drawing from MHSWs who are in frontline practice within NHS-MHS settings I was able to consider the *collision* between national initiatives to transform social work for mental health (Allen *et al.*, 2016), and the MHSWs access to discourses within the social practices of the NHS-MHS; a setting in which dominant discourses offer subjectivities and subject positions that conflict and contradict (APPGSW, 2016; Morriss, 2016) the visioned professional social worker subject constructed within strategic policy (Romeo, 2016). The intention of this research is to contribute to a call from Healey (2005) and Fook (2012) who argue that social workers would benefit from discursive approaches reflecting on professional social work practice, and from how both draw from Foucault's concepts when setting out their arguments. See Sections 6.6 and 6.7 for my discussion of the application of this research to MHSW practice.

2.4 Social practices

Foucault emphasised the importance of *social practices* within institutions (Foucault, 1977) and I found this concept very valuable in this research. Social practices, as distinct from the use of the term 'social worker professional practice' used in this research study, are the processes where things are said and done within an institution, and the purpose of research is to understand what the conditions are that make these practices acceptable at that moment. Therefore, I was not focused on a particular team or NHS-MHS, but what construct of professional self was possible for MHSWs in the contemporary policy and practice domain. Foucault described social practices as, 'where the planned and the taken for granted interconnect' (Foucault, 1978, p.225), and where the institutional regimes and orders of truth interface with material events, and meanings are socially constructed accordingly (Foucault, 1978). This had considerable relevance to social

worker subjectivities in mental health, where their subjectivities are constituted in and through the moment by moment context and notions of multi-disciplinary working, and by bio-medical discourses (Healey, 2005) and managerialism within the context of neoliberalist ideologies (Harlow *et al.*, 2012) constituting the person as subject, alternatively as 'patient', 'services user', 'client' and 'consumer' (Beresford, 2016).

Foucault argued that social practices – the specific regularities, logics, and self-evident rationales of a particular institution - construct taken for granted rules of meanings and assumed natural conclusions (Foucault, 1978, p.225). These taken for granted assumptions function to regulate orders of knowledge and powers of truths - what comes to be seen as urgent, a priority, and who can make the call in defining these and their existence. In analysing interviews with social workers, I have explored ways of doing and being that are described in their accounts. In particular, I focused on how they spoke of their 'selves'. For instance, as a professional social worker or a mental health team member in a NHS-MHS. In this way, the thesis explores how MHSW subjectivities are constructed in talk and social practices, and subject positions created or excluded by the discourse available.

This approach enabled an exploration of the way that various 'practices' constitute MHSW subjectivities examining which subject positions could and could not be taken by MHSWs within current discursive arrangements. This approach was also used to show how these subjectivities were sustained as relatively stable and consistent through their interconnections with other historic discourses and discursive formations of political logics, rules of profession and scientific truths within biomedical imperatives, each with internal rules, permissible meanings, logics and rationales of their discourses.

Discourse is a central concept within this thesis' research question and analysis, therefore by setting out how it is understood here makes critical evaluation of the methods and process more accessible. In particular, of the findings and subsequent discussion of their implications, by those who wish to use the research in practice. The nature of the term 'discourse' and how I have applied discourse analysis in this study is set out in the following sections. This includes drawing from Foucault's work the *Archaeology of Knowledge* (Foucault, 1969) to explain the notion of discursive formations and their ordering of discourses, and notions of power within discourses introduced in Foucault's work *Discipline and Punish* (Foucault, 1977). Also, an understanding of subjectivities as used in this research is drawn from Foucault's technologies of the self-emergent in his works *The History of Sexuality: 2* (Foucault, 1984) and Ethics: *Subjectivity and Truth, Essential Works of Michel Foucault Volume 1* (Foucault, (n. d.), in Rabinow,1994). Although I have not formally used a system of Critical Discourse Analysis such as Fairclough's (2010), I have taken a critical approach and have given an outline of my position as the researcher in this study. My intention in these following sections is to be clear about how I have used Foucauldian principles and where these have been developed, how they have been applied to the subject and the assumptions I have made in the research process.

2.5 Discourse

Discourse has had nuanced meanings in Foucault's work as his theories developed and shifted, (O'Farrell, 2005) but importantly it is seen as *discursive*; that is, discourse is taken to mean practices that systematically form the objects of which they speak (Foucault, 1961). The use of discourse as a concept assumes that the talk of the MHSWs is more than the use of language as a representation of material real events, but reflects verbal performances which contain ways of seeing the real which are drawn from different discourses. Each discourse belongs to a single formation of knowledge, understood through patterns of regulated language with internal rules that govern that specific discourse (Foucault, 1969). For example, the bio-medical discourses often dominant in the work place of MHSWs use terms 'patient', 'treatment' and 'diagnosis' thereby transforming and positioning people within a frame of socially constructed meanings. This discourse has a positioning function as it constructs the nature of the subject; it positions it in the discourse and the rules of the possible relationships between subjects. Each discourse sets up rules about who can occupy what subject position; a bio-medical discourse of mental illness draws truths from 'scientific biological expert knowledges'. This provides the frame of reasoning which permits who does what to whom, illness comes to 'exist' when a doctor diagnoses it in a patient. This also rules what subjectivities are possible; a 'patient' could not construct their 'self' as 'expert' on their illness and treatment when this is constructed through scientific bio-medical knowledges, but could construct their self as 'expert' on receiving services through subject positions constituted through 'patient' forums and engagement groups.

Discourses can also be seen to be regulated in relation to other discourses, such as discourses of professionalism and expertise, gender and managerialism. Discourse is where power and knowledge intersect (Foucault, 1969). In this way discourse can be seen to mean more than language, discourses have a power to produce subjects, objects and truths (Parker, 2002). In addition to the meanings and norms available within the discourses of NHS-MHS, discourses are assumed to be operating between all people and therefore, for example, notions of MHSWs held by shop assistants, family members, or a social worker's dentist. These notions would often be drawn from media discourses of social work, or personal discourses, and they would have power through those operations to shape the social workers' understanding of their subjectivities (Burman & Parker, 1993; Henriques *et al.*, 1998; Rose, 1999).

With these assumptions in relation to discourse and language when I analysed the social workers talk I assumed that reality, behaviours and the social workers' sense of self would be found within the language of their talk, and that language was always situated within the dominant discourses that shaped and allowed certain meanings and ways of seeing (Burman & Parker, 1993). Also, that language is not fully determined and the social workers had some agency, choice and control over the language they used in their talk. Therefore, social workers both used these discourses to construct their subjectivities and to resist others when there were competing notions of the self as professional social worker. Within the text of the social

workers interviewed there were regularities of patterns and structures resonating with discourses that made the constituted subjectivities possible. These patterns were seen to have the effect of circumscribing the positions for possible subjectivities. Therefore, discourses that were woven in the social worker's text were not neutral but tended to cohere to rules of meanings and significances; these constituted and made apparent the realities that were accepted and expected.

2.6 Discursive formations and regimes of truths

From Foucault's work, I have used 'discursive formations' to mean the organising principles of discourses at any one point in time; the world view, the organising knowledges and orders of authorities of that moment (Danaher *et al.,* 2000, p.21). I have used the term 'regimes of truths' to mean the collective of rules prevailing at a given time and place, according to which the true and the untrue are separated with specific properties of power attached to the true (Foucault, 1977). For example, within NHS-MHS where MHSWs practice, the scientific truths that provide the rationales underpinning the institutional practices of NHS-MHS, which in the order of discourses, gives power to biomedical discourses of mental health and constrains and delimits other discourses. I have assumed that the social workers interviewed for this research would not therefore just draw from or resist discourses within the social practices of the work setting when constructing their professional selves, but that these discourses are ordered within the wider prevailing discursive formations and regimes of truths specific to this period of history and English society at this time.

The following example is to illustrate how I have applied this theory within the research process. It is based on regimes of truths and discursive formation ordering clinical discourses and service users' discourses of mental health in NHS services at this time. Speaking of 'clinical effectiveness' and 'best practice' within NHS mental health frames cannot be ordered or formed through statements such as 'not feeling myself today' or 'I want to feel I'm myself again' - phrases often used by people to describe their experience of mental health problems. To produce 'best practice' in a clinical setting, talk needs to contain the 'reality' of mental illness. A reality built on 'expert' knowledges of what and when 'behaviours', 'observations' and 'symptoms' of a 'patient' constitute a mental disorder qualifying them to be in the services. This can only be legitimised through diagnoses and classification by a medical doctor. Therefore, within current NHS clinical governance frameworks and imperatives to deliver evidence based practice, the social worker has to 'see' with others within the social practices of the institution, the state of, for example, 'personality disorder', before it is possible to provide rationales for the delivery of any interventions, or argue an approach to working with that person. Therefore, discourses are not neutral but through regimes of truths and discursive formation affect and exert power within the social practices of institutions. Discourses impact on the socially constructed meanings of materially real events of social workers and the people with mental health problems using NHS-MHS.

2.7 Subjectivities

In this thesis as mentioned in the Introduction (Chapter 1), I took an alternative approach to understanding the concept of identity from the traditional notion of it meaning a person's unique, sovereign, boundaried psychological self. I assumed that social workers would not describe a definitive 'MHSW' but that they were bringing into being a sense of self, constituted through different subject positions and subjectivities, and that this may be changed to serve different purposes and may be done consciously or unconsciously (Fook, 2012). Placing subjectivities outside of binary concepts and allowing contradictory notions of realities avoids the forced categories of choice that binary systems set up, and the implied value difference or superiority of one in relation to the other (Fook, 2012). However, this does not exclude the individual having a sense of self that is continuous and coherent.

I used Foucauldian principles to understand identity as a self that is constructed in the form of subjectivities. This construct includes where the person transforms the self into the subject of a particular discourse, through a process of subjectification. Discourses and social practices hail the person into place as the social subject of a particular discourse, a concept known as 'interpellation' introduced by Althusser (2001). This produces subjectivities which construct the person as subjects of which can be spoken as they come to 'exist' through that discourse. Identity is therefore, a point of temporary attachment to the subject position which discursive practices construct (Hall, 1996). Foucault describes that subjectivity creates the self through:

> The way the individual establishes his relationship to the rule and recognizes himself as obliged to put it into practice ……a regular checking of conduct aimed at measuring the exactness with which one is applying these rules (Foucault, 1984, p.27).

Construction of the self is to sit within the discursive frames and social practices of the institution, and it is constructed through the way the person comes to understand themselves, their performative acts, and their place in the social order through social practices of the institution. Subjectivity acts to produce the self through how the person comes to evaluate the self as subject within the meanings constituted by the institutions' (social work profession and NHS-MHS) dominant regimes of truths and knowledges (Henriques *et al.*, 1998; Danaher *et al.*, 2000). Applying this to constructing the self as 'MHSW' it is reasonable to expect that this will be through subjectivities 'attaching' to different subject positions within discourses, constructing the self through the discursive rules regulating the constructs of 'professional social worker' (Banks, 2006; Open University, 2016) and constructs of NHS-MHS.

Foucault was interested in the power that discourses had to transform individuals and the order of truths to define, as part of that discourse, the 'real' about individuals (Foucault, 1961). He saw the action of constructing and positioning the subject within a discourse both as an external process through others and also through actions on the self. This recognises the person as both restricted but not passive in their construction of the self as a 'subject' that can be seen and made 'visible' through discourses within social

practices. A process that is in and out of awareness of the influences of construction, the person constitutes the self through practices in an active way: 'these practices are not the creation of the person but models found in their culture society and social group' (Foucault, 1984, p.291). The understanding of subjectivity used in this research does not attempt to explain all human phenomena of self and takes the position argued by Henriques (1998) that the self is not 'simply composed of a set of multiple and contradictory positioning or subjectivities… or that the individual subject is simply the sum total of all positions in discourses' (Henriques *et al.*, 1998, p.204), but the person will perceive a sense of continuity and consistency, with wishes, emotions and desires, and may repeatedly position themselves within particular discourses not explained through an effect of discursive practices (Henriques *et al.,* 1998).

2.8 Power

Knowledge and power within Foucauldian principles provides a very salient framework to apply to understanding social work subjectivities in NHS-MHS, because of the power-knowledge relationship, and orders of knowledge in the NHS setting within which they work, and dominant bio-medical discourses. Knowledge within Foucauldian principles is constituted of and through perspectives, rules, categories, explanations, terms, laws, narratives and definitions produced and validated by disciplines and institution. The power of knowledge, from a Foucauldian perspective, lies in its role in how people make sense of themselves in relation to systems of legitimised knowledge and their truths (Donaher *et al.*, 2000). Foucault took the position that power was not automatically negative but could be 'productive' as resistance to power results in constituting subjectivities and how the self is seen in the world. Resistance is a vehicle to question taken for granted claims of truth and falsehood to reveal the impact of the taken for granted on the moment by moment constituted realities (Foucault, 1969).

MHSWs professional selves are constituted from and within discourses (legal, biomedical, economic and political) that have more dominance (Healey, 2005) than the unique professional social knowledges, perspectives and skills that they are expected to bring to NHS-MHS. Social workers may draw from the more dominant knowledges which 'legitimise' professional subject positions within the social practices of the NHS-MHS. This may impact on how the social workers would make sense of their professional selves within the MHS-NHS, with subjectivities produced and producing contradictory, diverse and oppositional subjects within the discourses of MHSWs professional selves in the context of NHS-MHSs. Therefore, I considered it important to engage in the power element of discourses as part of the analysis process to move beyond simply reading the text, but also capturing where there were competing, prioritised and privileged discourses. Foucault explains:

> discourse is not simply that which translates struggles or systems of domination, but is the thing for which there is and by which, there is struggle, discourse is the power which is to be seized (Foucault, 1981, p.52).

Using Foucault in my approach to the research question, (see Sections 2.2 and 2.3), enabled an understanding of a relationship between the subject and power, knowledges, and regimes of truths. Through the history and culture of a particular time and place, people are transformed into subjects (for example professional, nonprofessional) and subjectively turn themselves into the subject (Foucault, 1982). I used this understanding to analyse how the social workers that I interviewed constituted their selves as the 'professional mental health social worker' subject within discourses. Foucault emphasised that within this relational power there are choices and possibilities to act differently. It was therefore possible to argue that this was not a deterministic framework but that social workers had some agency. I considered this would be most possible when MHSWs had their awareness raised through challenging assumptions of the 'natural' and taken for granted, and when choice could be exercised, then they could react and behave in different ways (O'Farrell, 2005). Heron (2005) draws directly from Foucault's concepts of power and subjectivity. She argues that the possibility of 'resisting reproduction of dominant power relations' is through self-reflection and the analysis of 'one's own subjectivity and subject positions' as part of critical social work practice (Heron, 2005, p.341). Applying Foucault's approach (Foucault, 1982), I assumed that instances of power would take place within the immediate relationships the MHSWs had with those close to them, and that I could understand these power affects by seeing where in the social workers' talk they resisted the truths and subject positions of a discourse within the social practices of the institution, and where the social workers produced alternative subjectivities.

The term 'positionality' is used within this research to recognise how discourses position the subject in relation to other subjects, and that different positions offer different assumptions about the nature of that relationship, including power differences (Davies & Harré, 1990). Understanding this aspect of subjectivities as constructed through and from discourses enables a richer explanation of the context of multidisciplinary teams. It was particularly relevant to addressing my research question stated in Section 1.5. It provided an understanding of how the discourses available to MHSWs within the multi-disciplinary team structures and the associated power imbalances, could move a social worker's construction of a professional self away from one drawn from programmes of professional social work, to a construction of a professional self that included medical truths and meanings that contradicted the self as a social worker (Fook, 2012).

Not all discourses have equal power and privilege; the strongest discourses are those which have grounded themselves on the natural, the sincere, the scientific, on the established components of what that society constitutes to be the 'true' and the 'reasonable' (Hook, 2001). Even with post psychiatry movements (Bracken & Thomas, 2005) and deconstructions of psychopathology (Parker *et al.,* 1995) NHS-MHS sit with regimes of truths underpinned by 'scientific' power knowledges constructing mental health illness. 'Good' services are constructed through visions in the form of 'clinical' standards based on medical diagnosis criteria, diagnostically informed evidence based practice and service delivery along diagnostic pathways - such as for 'personality disorder services' (Mental Health Taskforce, 2016).

One of the recent constructs of 'injustice' for people with mental health problems has been framed as inequities within NHS service provision, between them and people who have physical health problems; access to doctors, treatment and access to inpatient beds for their 'illness' (DoH, 2014a; Parkin, 2016). By equating mental health problems with physical health there is the risk of further medicalising 'mental health' and obscuring complex social components (Callaghan *et al.*, 2017). This can be argued as having the effect of reducing the power of drawing from social discourses, truths and knowledges to construct the self as a 'professional' and performative acts as 'professional practice' in those immediate moments of relationship within social practices of the institution. However, professional subjectivities and subject positions constituted through medical discourses would be more potent and legitimate within current regimes of truths constituting 'good' NHS-MHS.

2.9 Social work and Foucauldian approaches

Discourse analysis and discourses feature prominently in social work research and critique (Chambon *et al.,* 1999; Winter & Cree, 2016). Furthermore, social workers have been called to use discourse theory and analysis as part of a critical approach to practice (Fook, 2012; Healey, 2005). A benefit of this framework is to enable the social worker to step outside the discursive practices of the dominant discourses present within their area of practice, to realise they do not have to be accepted and to actively resist and contest them (Fook, 2012). Further to understanding the discourses that are impacting in the work context, responses can also reveal the role of discourses in social and cultural change within social work and mental health over time (Healey, 2005; Fook, 2012; Winter & Cree, 2016). This is a particularly beneficial aspect of this approach as social work has been subject to, and continues to be the focus of, numerous and frequent policy changes and notions of mental health and illness. This includes normalised notions of the population's responsibilities for self-care and health within neoliberalist reasoning, government responsibilities within new definitions of 'disability rights', and where mental health sits in relation to the constructs of illness and disability (Pilcher & Wagg, 1996; Payne, 2005; Beresford, 2016). Researched resources to support MHSW in NHS-MHS and particularly ones that take a discursive approach are scarce despite their value to social work being argued (Heron, 2005). I have outlined in Sections 6.6 and 6.7 how the research completed in this study will contribute as a practice resource for MHSW in NHS-MHS, for example, in supervision and training.

The use of Foucauldian principles in this research study was not without some concern for its suitability and robustness as an approach. For example, Sawyer argues that the current use of discourse did not originate with Foucault and that this has led to misreading of Foucault (Sawyer, 2002). I found it useful to consider the issues raised by Garrity in relation to social work research and elsewhere to monitor my own use and interpretation of the theory and terms as I completed the analysis and argued the findings. Garrity problematises the use of Foucault in social work research stating 'it is far from a ready-made model that may be applied' (Garrity, 2010, p.208) and that using discourse analysis can present a complex conceptual

minefield for researchers using discursive approaches (Garrity, 2010, p.194). Garrity argues that claims to the use of discourse analysis within social work literature have failed to appreciate the technical details of the term, leading to confusion and methodological failings, which can only be countered by placing its use within coherent and rigorous theoretical frameworks (Garrity, 2010, p.194). For example, other studies reported as using a Foucauldian approach have used the terms 'language' and 'discourse' as if they were interchangeable, making the point that Foucault was clear that discourses were more than language. Hook also raises focusing only on the language of a text as a failing in analysis, as it fails to use a more rounded approach to discourse analysis, missing the wider power relationships and orders of truths. He warns:

> As a result, discourse is not sufficiently grasped in its relation to power; the power of discourse is insufficiently engaged, and discourse analysis becomes more a project of reading the text than of engaging the discourse (Hook, 2001, p.8).

To address this concern, I have not used the term 'language' as traditionally understood as a form of communicating and representing material real events absent of discursive affects and constructs, but have used the term 'talk', meaning the speech of MHSWs when interviewed. In the process of analysing the talk of social workers I have set it within 'socially organised frameworks of meaning categories and [that] specify domains of what can be said and done' (Burman, 2007, p.2) and within the detailed understanding of discourse set out in Section 2.4 and discourse analysis in Section 4.9.

Chapter 3 A review of the literature

3.1 The approach to the literature: research, reports and policy documents

I completed a detailed review of the literature relevant to the research question stated in Chapter 1 from the perspective of the theoretical framework set out in Chapter 2. I took a discursive approach and looked for how the social worker and MHSW as subjects and objects (see Sections 2.3 and 4.11) were constructed and formed in the research and professional and policy documents. I considered what type of social worker and MHSW was produced, how these were constituted in the documents, and what was the nature of the 'real' and 'truths' assumed in these constructions. I positioned the literature review in this research, not as reporting on and discovering absolute truths, but as discourses constructing 'a real'. Also, that these discourses would have a positioning effect on the subjects they contained, revealing power relations between subjects and orders of discourse (see Sections 2.6 and 2.7). I explored the meanings the arguments and conclusions assumed to consider:

- How social worker and MHSW subjects could act
- What they could say
- How they were positioned in relation to other subjects (doctors, nurses, people)
- How they were positioned in relations to objects (professional, skills, evidence based practice)

I selected and analysed the literature from the perspective of its action in discursively forming the socially constructed meanings of 'MHSW' and as part of the process of informing the discourse analysis in Chapter 5 and as described in Section 4.11 of this thesis (Parker, 1992).

To find relevant literature I used a systematized approach (Grant & Booth, 2009) to searching electronic databases (including EThos databases of Doctoral Theses) accessed through the extensive University Northampton Electronic Library Search Online (NELSON) facility and Google Scholar. I also hand searched journals and personally e-mailed and made phone calls to authors who had written in this subject area. I limited the literature selected to documents in English but not limited to UK publications. In relation to the time period, because of the relevance of historical meanings and assumptions to the meanings of current discourses, I did not limit the search by a 'from' date. The search process started by using the primary conceptual focus of the research question (MHSW, subjectivities, NHS-MHS). Research literature using Foucauldian notions and literature in relation to MHSWs' subjectivities was scarce and I shifted to include literature that assumed traditional conceptualisation and use of the term 'identity' to increase the scope of the search. I also widened the search to include 'professional social work', 'social work roles' and 'integrated health and social care' combined with 'mental health services'. As a result of reviewing the results of these

searches I further widened the search to include 'specialism', 'training', 'education programmes', combined with 'MHSW' without limiting by including 'identity'. In addition to research articles, reports and policy documents I also used published works such as book chapters and professional social worker guidance published by active and cited authors in the profession of social work, (such as Ruth Allen, Martin Webber, Jan Fook, Karen Healey) as a resource to understand current constructs in debate.

I have arranged the chapter into key constructs emergent from my summary and analysis of the literature. I explore what the implications of the literature are for the production and construction of 'MHSW' in NHS-MHSs. As mentioned in Chapter 1, unlike nurses who train and qualify as a 'mental health nurse', qualifying as a social worker is not specialised and the professional programmes when completed produce generic social workers. How a social worker becomes a 'mental health' social worker is not an explicit or formal process but is often initially through personal designation (Morriss, 2017 personal communication), and constructed through personal experiences prior to training, placements whilst training but most often and more substantially, through the environment worked in once qualified, and post qualifying training linked to that post (Clifton & Thorley, 2014). The analysis below starts from understanding what constructs of 'social worker' are available before reviewing how 'MHSW' was formed in the literature and discourses of NHS-MHS.

3.2 Mental health social worker as professional

The production of social work as a profession can be seen as problematic through several lenses; an occupation more similar to a vocation, as a gendered profession and as a values-based profession. The following sections draw from literature debates in these areas. These tensions can be further understood when placed against traditional constructs of the concepts of profession and professional. Within discourses of profession the professional is expected to possess a large body of unique (to that profession) knowledge derived through extensive academic study. Professions are self-regulating, controlling the standards of training to achieve qualification and admitting new people into the field (Rengasamy, 2009). Like many other 'caring' professions, such as nursing, social work has been seen to fulfil the criteria of a vocational occupation which the person has been drawn to through personal experience and character. A vocational occupation is constituted as requiring a sense of selfless dedication to duty and putting the needs of others first (Abbott & Meerabeau, 1998). Additionally, in discourses of profession, social work is often categorised as a semi-profession, divided from 'true' professions whose expertise is based on intellectual skills and expert 'scientific' knowledges, by contrast their expertise as constituted through the acquisition of technical skills (Abbott and Meerabeau, 1998).

Another challenge to the construction of social work as a profession within traditional frames is that it argues to be recognised as a values-based profession. It contends that it is this that underpins its unique knowledges and skills, and sets it apart from other professions. These values are set out in the British Association of

Social Workers (BASW) Code of Ethics for Social Work (2012) which requires commitment to three basic values:

- Human rights – respect for the inherent worth and dignity of all people as expressed in the United Nations' Universal Declaration of Human Rights
- Social justice – a responsibility to promote social justice, in relation to society generally, and in relation to the people with whom they work
- Professional integrity – a responsibility to respect and uphold the values and principles of the profession and act in a reliable, honest and trustworthy manner

(BASW, 2012, p.8-10).

The ontological 'core' of social work is this professional values-base, and as Roche states, 'the language of values is fundamental to social work's definition of itself' (Roche, 2004, p.89). This suggests that values are more than an ethical code of practice; they *are* social work practice, as reflected in this statement in the 2016 Department of Health strategic statement on *Social Work for Better Mental Health*, about what MHSWs' core contribution can be to mental health services:

> Challenging discrimination and institutionalisation is core professional territory for social workers. Social work is rooted in a rights based perspective on needs and helping understand and use those rights (Allen *et al*., 2016, p 13).

This statement constructs social workers as the conscience of NHS-MHS: 'challenging discrimination and institutionalisation', and their professional function is to bring discourses of human rights and social justice to the social practices of the institution. Therefore, the professional social worker subject is constructed significantly differently to the traditionally framed professional subject, which is constituted through its discrete disciplinary and often scientific knowledges (Abbott & Meerabeau, 1998). This is in contrast to other professionals within NHS-MHS with whom the social worker may work. For example, doctors can claim a discrete body of 'causal' knowledges that can be communicated, reasoned and 'seen' within the social practices and regimes of truth within the institution - enabling the diagnoses of illness, prescribing of treatment and giving a prognosis. I suggest this transforms the construct of social workers from that seen within the policy drives for integrating services seen in Chapter 1, where the social workers' professional skills and knowledges, (social interventions, social models, social perspectives) are brought alongside those of health colleagues to broaden understanding of mental health (Coppock & Dunn (2010), LGA *et al.*, 2016), to position social workers as 'moral judge', acting on and brought into action by the practices of other professionals, rather than contributing unique disciplinary knowledges, producing two very different constructs of what 'professional' means. In contrast to the MHSW professional construct, the doctor as professional sits powerfully within traditional understandings of profession. When I used a Foucauldian understanding of power as set out in Section 2.8, this difference in constructs as professional suggested that

MHSWs' discourses of professional practice would be weakened within the context of the NHS-MHS multi-disciplinary team. Particularly if this meant MHSWs primary role in NHS-MHS was constructed as social agent monitoring the health professionals, acting as adjunct to their ethical codes, and if this replaced the construct of the MHSW professional with unique social knowledges and skills seen in national policy drives for integrated NHS-MHS. I explore the issues of social work as a profession and MHSW within NHS-MHS further in the next sections of this chapter.

3.3 A history of 'is social work a profession?'

Foucault has argued that history provides an 'excellent tool' for analysing existing regimes of truths, systems of thought and institutional practices (Foucault, 1988, p.11). What comes to be taken for granted is formed with assumptions and habitual ways of seeing that have their roots in past constructs of things - knowledges, truths, rules and regulations of what can be said, done and seen. I have drawn on this to consider how a regime of truth produced social workers as non-professionals, and that although social workers are constituted as professionals within today's constructs, some of its 'problems' arise from the past setting of the order of things (O'Farrell, 2005); these permeate reasonings and social practices framing the 'issues' of social work now. A recent report by the All Party Parliamentary Group of the inquiry into the *State of Social Work* constructs social workers as not understood, not respected and marginalised within the multi-disciplinary setting and a professional status in crisis:

> Social work with adults appears similarly challenged but with an even greater crisis in status than their children and families' counterparts. Often working in multi-disciplinary settings, social workers supporting older people, those with learning disabilities or mental health issues, among other groups, are too often marginalised, their roles little respected or even fully understood (APPGSW, 2013, p.8).

When considering *Is Social Work a Profession?* in 1915, Flexner, using frames and truths of that time, came to the conclusion that, even though it may want to be, and there were advantages to being recognised as one, that social work was not a profession (Flexner, 1915). The argument Flexner used was that to be a profession in the 'genuine sense' it had to be set against 'objective standards' (contrasting with desire to be and opinion that it should be) to be a profession. This traditional construct of what constituted a profession included that – 'the first mark of a profession is that the activities involved are essentially intellectual in character' (Flexner, 1915, p.154). Flexner qualifies this by explaining manual work is not excluded but the profession does not derive its essential character from its instruments but from the working of ideas into practice constantly accessing fresh supplies of facts 'deriving their raw materials from science' (Flexner, 1915, p.156). Another distinguishing feature of a profession, where Flexner uses the physician, engineer, and preacher as examples, is that its professionals are not under orders from others, are self organising and motivated by altruism.

The ‘profession’ constituted here is one where medicine is its epitome, unequivocally a profession. The reader is led by Flexner to the ‘truth’ of what a profession is: ‘we emerge from clouds of doubts into the unmistakable professions [medicine, law, engineering….]’ (Flexner, 1915, p.158). Within this frame, it is not possible for the social worker to be constituted as a professional. The reasoning with this construction can only produce the social work as helper and organiser of professionals. The knowledge and intellectual activity that social workers have is not original ‘drawing its raw material from science’, like medicine or engineering, but social workers have aspects of other professional knowledges (medical-legal). This enables them to problem solve which professional is needed:

> The very variety of the situations he [the social worker] encounters compels him to be not a professional agent so much as the mediator invoking this or that professional agency …[if] there is illness to be dealt with—the doctor is needed (Flexner, 1915, p.160).

The position of ‘social worker’ is further subjugated in relation to the ‘true’ professional position of doctor, and diminished by impermanency as social work is not professional practice, but supplemental, a component of the doctors’ and medical systems’ practice that they have yet to embrace:

> Suppose medicine were fully socialized; would not medical men, medical institutions, and medical organizations look after certain interests that the social worker must care for just because medical practice now falls short? (Flexner, 1915, p.161).

I argue that this is not Flexner individually constructing what a profession is but within his reasoning and ‘truths’, the real and order of things of that time are reflected. I suggest that these, although not explicitly stated, can be found within discourses, social practices and regimes of truth, that contribute to the framing and ‘seeing’ of professional social workers and professional social work practice within discourses of MHSWs and NHS-MHS at this time. Also, that this historic construction of ‘profession’ and the positioning of social workers in relation to it, and to doctors and the medical systems, continues to impact within discourses and social practices of NHS mental health institutions. I propose this gives an understanding of social workers’ struggle to construct ‘professional identity’ when completing professional qualifying education programmes as stated by Wiles (2013), and is ‘invisible’ in NHS-MHS as concluded in Morriss’ study of MHSWs who were working in NHS-MHS as approved mental health professionals (2016), see Section 3.12.

The professionalisation of social work continued from the time of Flexner through increasing programmes of study to underpin social work practice, and the development of professional social work organisations (Payne, 2005), with professional regulation and registration coming into effect from April 2005 following legislation passed in 2000 (Care Standards Act. (Part II.), 2000); a step seen as putting social work on a ‘professional footing’ (Thompson, 2009, p.196). Hugman observed that where social work has set itself apart from other occupational groups that have sought to establish themselves as professions, such as nurses, is through social workers’ engagement in social science debates about the nature of professions and the implications of professionalisation (Hugman, 1998, p.178). The construction of the social worker professional

self is not only constituted through claims to meet traditional standards of profession, for example research and evidence based social work practice, but also in a relationship of resistance to those traditional norms. This is particularly pertinent to the context of MHSWs who work alongside professionals, such as doctors, nurses and psychologists, in multi-disciplinary teams, in a NHS-MHS culture constituted through discourses and concepts of clinical effectiveness, evidence-based practice and performance outcomes (Bogg, 2008).

3.4 Social work an unboundaried construct

Programmes of professional education, standards of practice and roles function to boundary professional social work and social worker professional practice. However, this sense of boundedness becomes unsettled when what can legitimately be defined as social work is contested (Moriarty *et al.*, 2015; Manthrope & Moriarty, 2016). The argument made in the literature presenting a response to 'visioning' what social work roles plays in the future is that without understanding or having a sufficient consensus of what social work is, there are barriers to determining appropriate skills and expertise, training and education and what separates social work from other professions (Asquith *et al.*, 2005). There have been several attempts to define social work; including arguments for why it cannot be defined in an absolute sense (see Appendix 1 for definitions). Hugman suggests social work should be considered as a collection of different practices that have a flexible common core responsive to a different context (Hugman, 2009). Hugman maintains that no one part of social work can be privileged in claims of what social work is and to do this would be to distort and misrepresent a complex whole. The difficulty of establishing a stable and agreed definition of social work is a consequence of its origins and role in addressing welfare issues and morality at an individual and community level (Hugman, 2009) and as part of the industrialisation of society. Social work, therefore, as part of its nature, develops within the context of changes in the wider social structures and societal expectations (Payne, 2005; Gitterman, 2014).

Beresford (2016) has argued that discourses of professional social workers linked to community and social welfare have been overshadowed by vagaries of political ideologies resulting in changes to the nature, focus and imperatives of public services in the welfare system (Beresford, 2016). I considered Beresford's argument within the current context of the 2016 UK national referendum on membership to the European Union, where debates had focused in the media on economics and immigration (Allen *et al.*, 2015). Arguments within the debates framed public services, including NHS-MHS, in a context of an NHS in crisis on the verge of collapse and ongoing economic austerity (McKenna, 2016). Framed in this way financial investments in public services can move away funding social workers within discourses of human rights, social justice, antidiscriminative practice and community cohesion, to discourses of 'bed blocking' by older people, waiting times in Accident & Emergency departments, and 'NHS overspends' and the failings of social care to support the NHS system (The King's Fund, 2017). Returning to Beresford, I considered what changes in political ideologies could account for shifts such as this in what constitutes social work and what social

workers do professionally. Brown (2015) argues that the current dominant neoliberalist government's ways of seeing only produces policies that talk from an economic register of meanings. All other values, such as human rights, are therefore subjugated. Turning state policies and underpinning ideologies into competitive corporate frames that as a result have no place for equality and compassion for those who *have not*, as notions of winners and losers become naturalised within the countries' populations (Brown, 2015). Harlow has argued that neoliberalism has impacted on social work through managerialism and performance targets, and has reshaped social work practice. That in keeping with neoliberalist principles, it is not knowledge and skills that are the focus of what constitutes social work, but care cost reduction and satisfactory output of the number of social care packages completed (Harlow *et al.,* 2012).

Considering the issues outlined in this section, the unboundaried nature of social work as a construct has an impact on securing a stable relationship between social work and concepts of professional practice and constituting social workers as professional. A current construction of social care produced through neoliberalist ideologies manifesting in discourses of social work as prioritising cost reductions and increased output, would have implication for MHSWs. Working in the integrated setting of NHS-MHS, the MHSW professional self would be less stable and would be constituted very differently to their professional health colleagues, whose autonomy and disciplinary knowledge constitute their professional selves.

3.5 Social work profession and gender

The impact of gender on the conceptual construction of 'professional identity' and recognition of gendered discourses in relation to norms of professional status, continues to be debated and contested (Dahle, 2012). I acknowledged that gender factors have had an impact on the subject positions available within discourses of 'professional identity'. Also, that social work practices have been 'feminised' and viewed as not professional, within traditional frames of 'true professions' constructed from historically male domains of elite scientific knowledges (Dahle, 2012). I considered three ways that gender factored in social work. The first was that the nature of the work completed as a social worker is characterised as 'caring', 'natural' and an extension of women's work in the home as mother and wife (Khunou *et al.,* 2012). Morriss' study (2016) included interviewing 13 MHSW working in NHS-MHSs and was based on Pithouse's (1998) contention that social work is an invisible trade because it is completed in isolation, its outcomes are ambiguous and accomplished through taken for granted assumptions (Morriss, 2016, p.2). Morriss concluded that because of its nature MHSWs were unable to make social work visible to other members of the team, and that it required another social worker to see MHSWs' social work practice (Morriss, 2016, p.1). It is possible that there is another reason that, in this environment, social work is not visible that I suggest here. Abbot (1998) argues that caring has become naturalised as a family role held by women within the assumptions of the welfare system. Therefore, it is possible that the 'caring' work completed by social workers in the context of the NHS-MHS

and the 'harder' scientific practices of the doctors, becomes invisible as it blends with the naturalised constructs of caring within families.

Another gender factor in social work is that the majority of people holding the position of professional social worker are female. At the time of completing this study, 73% of social workers were women and a study by Furness (2007) found that from 2002 to 2005, 83% of total registrations for all pathways in social work were women. Within the service gender inequalities appeared to be replayed, although the numbers of women dominate social work there is concern that proportionately more men hold senior positions (Taylor, 1994; Davey, 2002; Khunou *et al.*, 2012). This suggests that men are promoted faster than women in social work. McPhail argues that this is because 'men take their gender privilege with them when they enter predominantly female occupations; this translates into an advantage in spite of their numerical rarity' (McPhail, 2004, p.324) and as they control decision-making positions, social work is thus not a female dominated profession but a predominantly female profession (McPhail, 2014).

A third factor of gender in social work is that although social work has also been described as service by women for women, Orme (2013) suggests that it has not necessarily been a productive area for feminist theory or practice. Social workers have received criticism from feminists charging them with holding women responsible for social problems, keeping them under surveillance, constraining them to subjugated roles and victimising them (Orme, 2013). Critiques of social work through feminist perspectives for example, Fawcett *et al.* (2000) and Orme (2013), argue that a feminist perspective has much to contribute to the practice of social work, particularly in, what has been argued as, the gendered nature of child protection in social work (Scourfield, 2001). Rossiter (2000) argues that traditonal social work truths and normative practices, (ones that targeted intervention with individuals, often women, who were judged to be falling outside of social norms of behaviour), should be rejected for more critical and discursive knowledges. Rossiter (2000) views considering the self as a subjectivity has significant implications for political developments in feminism and social work. For example, by the analysis of subjectivities and the discourses through which they are produced, it is possible to make visable the taken for granted frames that limit and diminish one way of seeing over another, origniating in dominant patriarchal ideologies and claims to the truth and the real (Fawcett & Featherstone, 2000; Butler, 2007). This can bring into consideration the subtleties of power, oppression and restriction on social worker subjectivities within the discourses of choice, autonomy, responsibility and professionalism acting on social work practice (Williams, 1996; Weedon, 1997; Fawcett *et al.*, 2000; Scourfield, 2001; Orme, 2013) . Although this is not the focus of this study I have been mindful of the debates within postmodern feminist approaches. By placing the analysis of the talk of social workers within a gender critique understanding of 'professional' it was possible to make visible the discursive practices challenging social workers' constructs of their professional selves and absence of subject positions possible within bio-medical discourses and social practices within the institutional regimes of truths.

3.6 Social work constructed through resistance to 'professional' status

The relationship of social workers to professionalising what they do and establishing social work as a profession has not been straightforward. It has included explicit anti-professionalism reactions by social workers most notable through the radical social work movement during the 1970's and 80's (Thompson, 2009). This rejected and moved against social work taking on professional status due to the power imbalances it suggested. It also framed resistance in the context of refusing subject positions and construction of professional hailed by LA and NHS intuitions' discourses of managerialism (see Section 3.4), and the implementation of neoliberalist organisational ideas of the productive and efficient professional employee in the context of performative frameworks (Harlow *et al.*, 2012). Tension and ambivalence has therefore arisen as social workers, based on the commitment to anti-discriminative practice and social justice (see Section 3.2), have been more use to positions focused on the empowerment of the people they provide a service to, and acting as a counter balance to professional and organisational power (Payne, 2005).

The uneasy relationship between social workers and being a profession is also reflected in social work's complex relationship to regulation. Political agendas and oppressive motives have been attributed as underpinning government actions in this area (Payne, 2005). The government attempts to construct what social work is in an effort to serve its own image of state regulation of individuals, reaching into their own homes and communities. Tensions surface as there is resistance to regulation defining and constructing social workers, not as autonomous professionals, but as extensions of the government and agents of the state (McNicoll, 2017). Baxter (2011) brings this into her analysis of public sector identities when she quotes Bradford's observations. In the first extract Bradford makes the connection between government and utilisation of professions to extend its impact on defining social problems and their solutions:

> Professions and professional practice are central to the project of government. Indeed, expertise institutionalised in professional form has increased the reach of the state in its capacity to represent social problems in such a way as to make them amenable to government practices (Bradford, 2007, p.22).

However, this is not straightforward as seen when reading the sentences in Bradford's article following Baxter's extract, where social workers are positioned as also having self-interested motivations:

> As occupational strategy, professionalism has characterised the helping occupations since the war and some aspirant professionals (social workers, health visitors, occupational therapists, and latterly, youth workers) elicited public and political support, so acquiring a mandate to practice within the welfare state. Professionalism is also a power practice, an attempt to achieve closure by producing a commodity whose acquisition and distribution is assiduously monopolised by professionals themselves (Larson, 1977).
>
> (Bradford, 2007, p.22).

In relation to social work as the focus rather than the instrument of government control, there have been recent debates regarding the impact of the current version of the Children's and Social Work Bill (2016) if it is

passed by parliament. The Bill links *Improving Standards of Social Work Care* with setting up a government controlled body to regulate social workers, which would be allowed to bring criminal charges against social workers if they did not comply with the regulations set by government. Concerns have been raised that this has implications for professional independence and freedom to define best practice on social work theory and research rather than government ideology (BASW, 2016). Regulation and registration has been a contested issue for and by social workers and in contrast to other professions, such as nursing, social work remained an unregistered profession until 2005 when it was legally constituted as a profession through a series of Acts of Parliament (see Section 3.3). From the 1st April 2005, it became illegal for an individual to describe themselves as a social worker if they were not registered with the regulatory body, which at the time was the General Social Care Council. From 2012 regulation and registration of social work moved to a newly created body, the Health and Care Professions Council, which also regulated 15 other professions including art therapists, hearing aid dispensers and prosthetists (Health and Care Professions Council, 2016).

When registration and the accompanying code of practice were introduced they were argued as degrading social workers through an implied view of them as 'simultaneously assessors of risk, at risk and as a risk' (McLaughlin, 2007, p.1263). Moral character had always been important but the new registration and regulations made more acute the scrutiny of character and for some was 'a worrying development' (McLaughlin, 2007), impossible and unjust:

> It is likely we would all want to promote public protection and professional accountability but the current operation Social Work Education of English fitness to practise procedures is in danger of undermining both as we have students signing up to expectations they are not in a position to fully understand or comprehend. If we do not address this injustice it is likely you will need to be a saint to be a social worker, or to have a very good lawyer! (McLaughlin, 2010, p.93).

The challenge for professional social work educators and those overseeing the recruitment and development of students in becoming professional social workers, is seen as the balancing of the fundamental value base of social work and its commitment to anti-discriminatory practice, and the decisions and control over who is deemed professionally suitable to practice as a social worker (Wiles, 2013). I considered that this suggested a tension between externally and politically legitimised technologies, a term used by Foucault to refer to the means that norms are transmitted, (such as state set standards of professional practice), of what constitutes 'safe' and 'public practice', and a resistance by social workers that was postmodernist in nature (Rose, 1999). A resistance to social work and social workers being constituted through universal and dualist ideas of good and bad, right and wrong, that impose a notion of 'improving standards' that is reductionist, restricting and instrumental in oppressing social work's antithetical political positioning to government and its rights to professional self-determination. Therefore, the notion of 'professional identity' for social workers is multi-faceted, contentious and an area of struggle within the meanings of regulation and what those do to the positioning of social workers in relation to 'the state and government' and the people with mental health problems they work with day to day in practice. Also, I would argue, there would be benefit to the

contradictory rationales of why a profession based on values of social justice, protection of the vulnerable and anti-discriminative practice produced as performative acts to construct 'being a social worker', requires a regulatory framework constructed by the state to declare that it is 'fit for practice'.

3.7 Constructed as 'the problem'

Social workers are not the only professionals seeking to establish a robust professional identity in mental health, mental health nurses are also arguing for recognition (Crawford *et al.,* 2008; Hurley, 2009; Barker & Buchanan-Barker, 2011). Baxter, (2011) in her literature review of public sector professional identity, places this struggle for coherent and robust professional 'identities' in a multifariously challenged environment - increasing marketisation, a drive for multi- agency working, and economic austerity resulting in 'the biggest spending cuts since the Second World War' (Baxter, 2011, p.9) - and with reactive politically motivated government responses to failings and public pressure and 'policy turbulence' (Bradford, 2007; Baxter, 2011, p.9). Social workers and their profession are constructed in these discourses of professional identity as simultaneously one that is *essential* but not respected by the public in general. This position and positioning of social work can be drawn from the following extract which is taken from an inquiry into the state of social work:

> Social workers are among the most essential yet maligned of public servants. They are criticised to such an extent their work is often discussed and their profession roundly disparaged by the public at large (APPGSW, 2013, p.5).

The issues facing professional social workers, raised in discourses of social work, are numerous:

- Increasing and unmanageable caseloads
- Reduced LA budgets affecting both funding salaries and placing pressures on social workers to reduce spending on care
- The division of Government responsibility between two departments (Department of Education for child social care and Department of Health for adult social care), which are pulling in two different directions
- Professional education with training and career pathways that are confusing and inadequate
- Problems with recruitment, retention and poor working conditions
- Negative media coverage and political agendas construed as blaming and 'scapegoating' (House of Commons Education Committee, 2016; Galilee, 2005; Stack, 2010).

The concern for social work as a profession culminated in 2009, with the Secretaries of state for Health and for Children Schools and Families commissioning a Task Force to critique why social work was 'currently not flourishing' in England (Social Work Task Force, 2009, p.3). The report found that social work in England 'too often falls short of the basic conditions for success, with weaknesses in recruitment, retention, frontline resources, training leadership and public understanding success (Social Work Task Force, 2009, p.6). The

Government published its response to the report in 2010 (DoH, 2010) with a list of fifteen recommendations, see Appendix 2. The discourse of both documents (the report and the response) constructs the context of professional social work practice as highly challenged and problematic from several perspectives; calibre of entrants, professional training, standards of employers, public understanding, and leadership (DoH, 2010, p.25). However, the crisis in social work is often concluded as one of identity and that there is an urgent need for social work to clarify its professional identity (Asquith *et al.,* 2005). This also surfaces in later reviews of the literature as in Moriarty *et al.*'s work (2015) and current national initiatives by the government to define social work in mental health care (Allen, 2014). Baxter makes the case that there is an unprecedented volatile arena for public service practice currently, that includes political and economic uncertainties, therefore it is more important than ever that professionals create and sustain professional identities that are salient and robust to enable them to work effectively (Baxter, 2011, p.13).

These discourses have the effect of setting the focus of the problem within the social worker subject, although understandably they have problems with their professional identity because they are working in an extremely challenging environment - for example economic austerity and policy turbulence. The nature of the 'profession' is such that it is both the problem and the solution, as the call in the discourse is to the social work profession to 'create and sustain salient and robust' professional identities (suggesting they currently are not) which will then enable them to 'work effectively' (Baxter, 2011). An alternative understanding of these issues, drawing from Foucault's (1978) call to the researcher to challenge ways of seeing, would be to frame constructs of the concept of profession in such a way that it was possible to accept the nature of social work, for example as values-based, as *robust* and to 'see' it as a profession. Then the call for solutions to the challenges facing social workers to *practice effectively* could shift, locating answers, responsibility and change within societal and political norms, ideologies and policy practices.

Analysis and review of the literature produces the profession of social work as challenged by its different form and functions to traditional frames (see Sections 3.2 – 3.6), and its positioning within political, public and media discourses framing societal problems in crisis, failing, and where change needs to happen. Awareness of the themes drawn out in relation to the social construction and production of social work as 'profession' provides part of the discursive structuring of 'MHSW'. The following sections focus on the literature specifically related to production of the construction of 'MHSW' within NHS mental health settings.

3.8 Media discourses and politically incentivised shifts in public image

Discourses framing social work as a profession that has failed society, misunderstood by the public and negatively reported on in the media (Social Work Task Force, 2009; DoH, 2010), did surface in the talks of social workers and the subjective professional self within existing literature. An example of the language used to *authorise and proclaim* this position of social workers can be seen in the extract in Section 3.7, which places social workers in a solitary and unique position (APPGSW, 2013, p.5). The way in which social work

and social workers have been specified and brought to public notice through negative discourses of 'what they are' has been attributed in the social work literature to politically motivated and biased hyperbole in the media.

A review by Galilee (2005) surfaces the perception that UK media representation, particularly in the press, of social work is unfairly negative and biased against social work and social workers. When surveyed, social workers believed that negative reporting resulted in hostility from the public and mistrust by service users. This is in considerable contrast to the public's satisfaction with doctors and nurses who are viewed as highly trusted professionals (The King's Fund, 2016), who are often colleagues and members of the same teams as social workers. Galilee's review identified several reasons for the negative presentation of social work in the press found in the literature. One observation suggests that social work comes into the news only when it can satisfy journalistic criteria of being 'newsworthy' such as immediacy, simplification, titillation, personalisation and novelty. Most social work stories do not meet these criteria. However, social work failures, particularly those that involve children such as the death of Victoria Climbié and the child known as Baby P, are viewed as newsworthy (Galilee, 2005). Galilee also placed in his review reference to the impact that negative press coverage has had on staff morale, citing a link to staff absences, problems with retention and recruitment, and difficulties with promoting social work as a career. I considered the question what does this produce in the subjectivities of social workers, the tension between the national and public discourses that construct social workers as failing and criticised by the people it is committed to advocating for and helping, and the importance of the value base of social work as a profession? Galilee's recommendations to address images of social work in the press mainly focused on improving and increasing the competency of Local Authorities and social workers in media skills, developing media strategies to promote positive practice and access to national specialists who are media 'savvy'.

For example, as a result of support by the 'Conservative' press of a 'New Right' neo-liberalism aligned to Thatcherism, the social democratic values of the welfare state and full employment were challenged, and replaced with values of freedom, free markets and freedoms of the individual and constructing state interventions as an intrusion to individuals' rights both economically and morally. Winter & Connolly (2005) argue that the media, particularly the Conservative press, created 'folk devils' representing anyone whose job, attitudes or practices reflected the values of social democracy, therefore social workers were 'demonised' as most obvious products of social democratic ideological principles (Galilee, 2005; Winter & Connolly, 2005). Franklin & Parton (2001) are cited by Galilee to introduce the argument that because of who social workers care for - the poor, disabled, elderly and sick - they represent a critique of the family and community, and therefore, of government and society.

Previous sections in this chapter have been concerned with discourses which problematised 'social' work' as a profession; in the following sections I look specifically at the additional discourses that relate to the construction of the professional self as 'MHSW'.

3.9 Constructing the mental health social worker

As discussed in Chapters 1 and 2, the subjectification of the self as 'MHSW', the bringing of oneself into being within discourses and social practices as the 'mental health social worker' subject, different to the 'social worker subject', is not achieved through training and qualification as a MHSW but emerges after generic social work training. It may start through personal events and self-designation, from experiences of having a member of the family with a mental health problem or a commitment to working with this group of people as one of the most vulnerable in society (Morriss, 2014; Morriss, 2017). Educational programmes to obtain a professional qualification as a social worker are generic and not specialised, unlike nurses who train and qualify as a 'mental health nurse'; social workers have no formal or specific process to 'become' 'MHSWs, it is formed through placements during initial professional training. This can be a problematic route to construction as a professional moving from training to qualified practice and genericism or specialism in the qualifying degree of social work has been a raised as 'an absolutely key issue' in social work education (Croisdale-Appleby, 2014, p.64). Wiles' study into social workers' construction of their professional identity also framed the shifted position of student social worker within professional educational programmes to post qualifying positons of occupation, as where the social worker professional identity is crucially formed (Wiles, 2013). She situates professional social worker identity as complex, ambiguous and diverse as a professional norm, and calls for educators to recognise it as such (Wiles, 2013). She states that 'becoming a social worker requires the student to do significant identity work' (Wiles, 2013, p.862), with diverse and partial visions of the qualified 'professional social worker' to construct the norm on completion. Healey's search for a critical understanding of professional social work practice was driven by difficulties she encountered as a newly graduated social worker:

> My first two years of graduate social work were extremely difficult…..I encountered a great deal of hostility, mostly within my organizational context … about the humanist and contestant ideals, that I, in my sincere but naïve approach, was seeking to 'share' or even 'impose' …I became aware of … the limits of the formal base of social work for helping me achieve change in practice, at the same time I became more attuned to the extent to which the institutional contexts in which I was working provided opportunities for, and limits to, the realization of human values to which social workers are committed (Healey, 2005, p. xiii).

This does not produce a 'real' world where the professionally educated and skilled social worker is providing a service to others, taking up positions in response to calls for those unique skills and knowledges, but one where the professional social worker self has to be reconstructed to produce a coherent subject within the discourses and social practices of the institution within which they work. Therefore, for those who become MHSWs after qualifying, the discourses of their work environment (NHS-MHS) are active in simultaneously

forming and constructing the professional self as 'mental health social worker' and as 'professional social worker'. Social workers often become MHSWs through taking up posts within NHS teams such as a CMHT (Clifton & Thorley, 2014). This is where they are seen to develop the skills and knowledge of their specialism through formal and informal learning (Moriarty *et al.,* 2015). The implications for social workers' professional identity, of gaining their mental health skills through working within NHS mental health teams after they have qualified, has raised issues about the suitability of social worker training for mental health and the impact on identity development (Blinkhorn, 2004; Clifton & Thorley, 2014; Baxter, 2011; Wiles, 2013).

Therefore, for newly qualified social workers who take up positions as MHSWs in NHS-MHS the complexity of constructing a professional self can be seen through the use of new subjectivities needed to construct the self as:

- Qualified professional social worker rather than student social worker
- Specialist social worker different to adult social care generic social worker
- MHSW, outside of the LA culture where discourses of social work and social care are dominant and inside the culture and dominant discourses of the NHS-MHS

The discourses that MHSWs can draw on to construct 'social worker' subjectivities in the context of NHS-MHSs are limited, unlike other areas of professional social work. MHSWs are lined managed and are appraised within frames of NHS regimes of truths and discursive practices. MHSW draw very little into their construction of a professional self from the usual social care culture, environment and systems of the LA (Clifton & Thorley, 2014).

Therefore, 'MHSW' (in contrast to the subject as social worker or specialist social worker) is constructed from subjectivities and subject positions possible drawn from discourses and social practices within NHS mental health systems. This can be further complicated if social workers are employed by the LA but seconded to the NHS-MHS as part of the delegation of the LA's Adult Social Care statutory duties, as defined under an Act of Parliament, currently the Care Act 2014 (2014), to the NHS-MHS. LA duties are poorly understood within NHS-MHS (McCrae *et al.,* 2004; Bailey & Liyanage, 2012) whose priorities and structures will reflect 'health' imperatives and forms. Social workers are a small minority within these services and they can become adrift from the LA's social care culture as a source for framing discourses of social care 'professional practice'. The NHS priorities and culture can become more natural to the social worker as ways of prioritising and understand work agendas (Colombo *et al.*, 2003; Clifton & Thorley, 2014).

Questions are often raised in the literature as to whether social workers' secondments to NHS-MHS overshadow, oppress, or strain 'unique professional social worker values' and priorities (Godden *et al.*, 2010; Allen, 2014; Allen *et al.*, 2016). Also, the practice of interventions based on social perspectives (Ray *et al.*,

2008; Gilbert *et al.*, 2010; Tew *et al.*, 2011), with the implication that would have for constituting the professional social worker self. In the literature this is connected to practical implications for social workers such as blurred roles when working in multi-disciplinary teams (Brown *et al.*, 2000), weak or unclear 'professional identity' within the work setting linked to work place stress and low morale (Geng *et al.,* 2011; Lloyd *et al.*, 2002; Huxley *et al.*, 2005; Johnson *et al.*, 2012), and that social workers 'professional identity' is under threat and could be lost (Carpenter *et al.*, 2003; McCrae *et al.*, 2004; Nathan & Weber, 2010). These representations form visions of mental health social work as under siege, and MHSWs practicing in a context of fear for their professional status. The purpose of this thesis is to explore these issues through the question of how do MHSWs construct their professional selves in NHS-MHSs, what subjectivities and subject positions are possible and what are the implications for social work pracice?

3.10 Social workers and NHS mental health services

This thesis takes the position that the dominant culture within NHS-MHS is a 'bio-medical health' culture, and has been shaped by forms of managerialist and neoliberalist economic principles of performance and effectiveness. In addition, social 'understandings', 'models', 'values' and 'perspectives' are subjugated and marginalised within this context, and by placing social workers within NHS-MHS affords opportunities for them to act as cultural change agents (Chapter 1). However social workers are in the minority within the NHS mental health teams in which they work, (social work as a profession is small when compared to nursing)**,** and nurses are not only social workers' peers but often their managers within NHS mental health teams. The Health and Care Professions Council's Register of Social Workers does not differentiate between adult or children's social workers, generic or specialist, or social workers' specialisms such as learning disability or mental health, so it is not possible to state how many specialist mental health workers are currently registered. At the end of the year 2016 there were approximately 91,750 social workers registered whereas there were an approximate total of 692,500 nurses and midwives.

Although there have been professional initiatives to attract people to train and an increase in numbers of people qualifying as a social worker has been achieved, there has been a significant reduction in the number of adult social care posts as Local Authorities attempt to meet budgetary targets (Clifton & Thorley, 2014). Despite increased numbers of social workers qualifying, the comparatively small size of the profession and the reduced number of posts within Local Authorities, some local authorities have a very high vacancy rate for social workers of over 20 per cent. Overall the social work vacancy rate is higher than that in nursing (Clifton & Thorley, 2014). There is a particular shortage of adult MHSWs and Local Authorities have reported significant challenges in recruiting social workers to work in mental health settings (Croisdale-Appleby, 2014). In a survey of newly graduated social workers completed by Sharpe and colleagues (2011), knowledge of mental health issues was raised as an area of anxiety in relation to fitness for practice:

> …the study [Into the Workforce] confirmed that there were certain areas in which some skills and knowledge were reported to be lacking among newly-qualified social workers. Consistent with other reports (Social Work Task Force, 2009; Bates et al., 2010; Carpenter et al., 2010), graduates responding to the online surveys wished they knew more about dealing with hostility, aggression or conflict; assessing risk; the evidence base for their area of social work practice; mental health; and the legal basis for social work interventions (Sharpe *et al.,* 2011, p.141).

I argued in Section 3.9 that social workers do not take up working within NHS-MHSs with a preformed or sustaining resource of a MHSW subject to construct a professional self. The MHSW subject is constructed and reconstructed from the discourses within the NHS-MHS, formed within discursive frameworks and social practices of the institution. In addition, the extract above suggests programmes of professional social work education and training place 'mental health' as an object outside of the remit of social work with people. Mental health is a thing to be understood in itself as the phrase states they wish 'they knew more about ... mental health' to be fit for practice. I suggest that this moves meanings of mental health away from a holistic understanding of people, which includes mental health as a part of overall wellbeing, to a meaning similar to that of mental illness, something with a body of specialist (medical) knowledges of its own, which the social worker needs so they can understand it; knowledge that is separate to general understandings of people. If 'knowing' 'mental health' is important to discourses of social workers' fitness for practice the implication for mental health social workers is, are bio-medical discourses better discursively positioned than social discourses, to construct specialist mental health knowledges and produce the specialist mental health social worker self?

When looking closer at knowledges used in mental health care there are very few that are disciplinary unique. Medicine provides theories of diagnosis and treatment, and psychology offers theories enabling formulations of presentation and rationales for a disorder specific intervention, but most professional programmes for mental health training, such as psychiatry and mental health nursing, includes drawing from a range of disciplinary knowledges such as sociology, pharmacology and neurology. There can be several consequences to this overlap within the professional's disciplinary knowledges; confusion and blurring of roles, developing of subjectivities constructed more through treatment interventions delivered by the team than professional origins and although spoken of as *multi*-disciplinary and *multi*-professional, the team truths are constituted through the strongest of the overlapping knowledges. For example, medicine, which has historical congruence and coherence as well as validation through mental health's place in a national *health* service. Psychology has found an increasing space for existence through its ability to offer 'clinical' and scientifically substantiated interventions accessed through diagnostic criteria. For example, if a person is diagnosed by a doctor as having a borderline and antisocial personality disorder, psychological interventions can be 'prescribed' to elevate 'symptoms' (NICE, 2015), without challenging the bio-medical ways of seeing, knowledges or truths of mental health.

The impact of locating the 'knowing' of 'mental health' within bio-medical discourses and the construction of the social worker as MHSW within NHS-MHS is that social workers' subjectivities and constructions of professional self are located within naturalised norms of medical dominance and structural oppression (Auslander, 2001; Probst,2012; Bailey & Liyanage, 2012). The concept of 'professional social worker' becomes troubled when framed by this culture, and struggles to define itself within the context of a health system with many other 'powerful professionals' (Beddoe, 2013). Bywaters (1986) emphasises the position of social work in the context of medicine as one that puts it at odds with other professionals as a result of fundamental difference of social worker beliefs in relation to a service user's self-knowledge and right to 'choice', and their expectation of a more mutual relationship in terms of understanding and deciding care. The title of Bailey and Liyanage's research paper, *The Role of MHSW: Political Pawns in the Reconfiguration of Adult Health and Social Care* (Bailey & Liyanage, 2012) was based on their findings from a thematic review of studying MHSWs working in NHS mental health teams. This positions social workers as minor players, *pawns,* in a service dominated by health where there was stigma in being a MHSW and reduced status compared to colleagues from other disciplines (Bailey & Liyanage, 2012, p.1113).

If the MHSW professional self is constructed from a relationship between mental health as object and MHSW as subject with specialist knowledges of that object, the bio-medical discourses of mental health privileged within the NHS-MHS environments in which they work, will have a significant impact on how that self can be constituted. The argument to place social workers within the NHS-MHS to be cultural change agents, and a counterbalance to medical models assumes a boundaried MHSW self exists, with alternative social knowledges and constructs of mental health. This can be 'seen' most explicitly in the government policy documents for 'modernising' NHS-MHS that were produced and implemented from 1999, when the Labour Government's National Service Framework for Mental Health (DoH, 1999) was published up to 2011, when the Conservative and Liberal Coalition Government refocused NHS mental health strategy with its publication, *No Health without Mental Health* (DoH, 2011). The following sections focus on the 'MHSW' as constructed in policy during that period.

3.11 Policy production of the mental health social worker

The newly elected labour government of 1997 set an agenda for extensive reform of adult NHS-MHS; it declared mental health services at the time as in *need of urgent modernisation,* they were to be, *Safe, Sound and Supportive* (DoH, 1998). Discourses of community care already existed following the broader reform of health and social care under the Conservative Government's National Health Service and Community Care Act 1990 (1990a). This Act introduced new notions of the duties for LAs to provide social care to support vulnerable people in the community and discourses which assumed that health and social care services should work together. The 1990 Act framed responsibilities for care within ideas of 'community' and discourses that shared the responsibility for people; older adults, people with learning disabilities, people

with physical disabilities and people with mental health problems, across health NHS services and social care LA services. It shaped this role for social care and social workers *outside* of NHS institutions through the introduction of care management and care managers to support peoples' independence from services under Section 47 of the Act (1990b). Additionally, social movements, such as the National Advocacy Group and Survivors Speak Out, driven by human rights, campaigned for change in NHS-MHS. People with mental health problems who had used services published personal accounts of their experience of abuse and harm (Chamberlin, 1988). This was the context that social workers were brought into NHS-MHS through one of the most significant transformations of mental health services, the National Service Framework for Mental Health (Gilburt & Peck, 2014).

Where there had been an absence of 'technical' constructs underpinning NHS-MHS, the NSFMH launched by the Labour Government in 1999, interwove scientific discourses (bio-medical, research and evidence based service models), with rationales underpinned by neoliberal managerialism (DoH, 1999; DoH, 2001; DoH, 2002). This produced new ways of constructing people residing in mental institutions, from a position of needing confinement in a separated institution, self-sufficient within the boundary of the hospital confines, to logics of social inclusion with calls to remove oppressive barriers to human rights (Pilgrim & Rogers, 1996). The NSFMH has been described by Lilo (2016) retrospectively as the real push to create multi-disciplinary teams and integrated services in mental health, and it explicitly placed the role of social workers' presence *inside* NHS-MHS.

The NSFMH brought to discourses of mental health the 'real' of specialist evidence based multi-disciplinary community teams as a standard of excellence in the construct of 'modern NHS-MHS'. It was based on logics of a 'biopsychosocial' understanding of mental illness (Turpin *et al.*,1988) where the predisposition and manifestation of biological illness of the patient interacts with their psychological features and social factors of their environment (Vaughn & Leff,1976). Based on this understanding of mental health, the person with mental health problems is 'seen' as complex with needs that draw from multiple professional disciplines. Therefore, the rationale to frame changes to NHS-MHS to bring these professionals together to deliver 'treatment of mental illness' through a single process was made possible. The NSFMH introduced ways of constructing mental health care as strategic and specialised, for example, by forming teams around early intervention in psychosis and teams providing crisis resolution and home treatment as separate to routine care. The document also created ways of talking about 'modern' ideas of what constituted a complete service, a service focused on and provided in the community. Publications, such as the Sainsbury Centre for Mental Health's *Pulling Together* (SCMH,1997) and *The Capable Practitioner* (SCMH, 2001a), contributed to discourses and rationales providing the reasoning for which professionals should make-up the teams, the functions the teams should fulfil and the interventions that should be offered, consolidating drives for integration through constructs of expected professionally shared capabilities.

These documents cohered to provide discourses that negated contradictions by the naturalised truths of these teams, constructed both as other professionals contributing discrete unique knowledges of their professions within the same space as these professionals. Professionals providing integrated health and social care, within positions as generic mental health professionals with a shared capability base Coppock & Dunn, 2010). The detail needed to be followed to replicate the research outcomes and therefore the Policy Implementation Guides (DoH, 2001; DoH, 2002) and workforce guides were published which constructed professionals through functional capabilities, rather than professional knowledge and expertise. Under notions of new ways of working (DoH, 2007) the functions, skills and nature of the teams were defined and what was meant by care coordinator as an important concept in NHS-MHS was specified. The guides also instructed the number of doctors, nurses, occupational therapists, psychologists and social workers that were to make up each type of team and ratio of staff to population to be covered. This initiative, which was paired with financial investment and specifications for how it should be implemented through local stakeholder forums (DoH, 1999), was a very conceptually populated and cohesive construct, which can be seen to have squeezed out the space for any alternative discourses of social care and professional social worker subjectivities in mental health.

The implementation guides (DoH, 2001; DoH, 2002) positioned social workers as making a discrete contribution, with valued professional skills and knowledges, enabling comprehensive attention to covering different aspects of mental health needs of the individual, and notions of a 'bio-psycho social' understanding of mental illness. This ignored, as argued in Section 3.10, that doctors' (psychiatrists) and mental health nurses' professional training draws from several disciplinary sources. Also, placed in the background and in the shadows at that time were other discourses, knowledges and truths. For example, the benefit of medical theories of mental health, underpinning frameworks of evidence based practice, are contested (Bracken & Thomas, 2005). People who had had mental health problems were challenging traditional constructs of health and social care, and 'public service' understandings (Beresford & Croft, 2001). There were also alternative ways of constructing 'effective' mental health care through placing the focus on populations, children and families rather than 'secondary care' and 'mental health services'. A focus that could be argued as equally evidenced based but constructed through traditional institutional discourses of mental illness. This alternative way of seeing the imperatives for mental health can be found in public health arguments prioritising the social determinants of mental health, effects of social inequalities in childhood on mental health and the developmental factors of mental health and 'illness' (Royal College Psychiatry, 2010).

The government's policy document *The Journey to Recovery -The Government's vision for mental health care* (DoH, 2001), also brought the 'person' and the person's relationship with their mental health problems from outside in the community to inside the NHS-MHS. This wove discourses of recovery that emerged from civil rights movements into discourses of new ways of thinking about NHS-MHSs (Anthony, 1993). Originating outside mental health institutional systems, when described through people with mental health problems,

recovery discourses 'were deeply personal and unique, involving the development of new meaning and purpose in one's life' (Anthony, 1993, p.527). These discourses were also interwoven with discourses of social inclusion and set an alternative focus for professional practice in NHS-MHS (Repper & Perkin, 2003). What was 'modern' and 'good' practice moved away from illness and symptoms, to what was meaningful in a person's life: their home, family, friends and community (Shepherd *et al.*, 2008). Recovery discourses brought into NHS-MHS 'social' discourses that offered social workers an alternative to bio-medical discourses alone and a resource to construct a professional self more resonant with the core constructs of social work as a profession. However, a study by Khoury & Rodriguez del Barrio (2015) which interviewed MHSWs in relation to implementing 'recovery' within health care settings as part of service reforms, reports that 'managerial orientations' to recovery orientated practice within reform 'paradoxically led to barriers' to the social workers' 'recovery orientated practice' (Khoury & Rodriguez del Barrio*,* 2015. p.27). I suggest that the meaning of 'recovery', when used to provide logic and rationales for NHS service transformation within policy discourses, becomes differently and *paradoxically* reconstructed within the social practices of NHS-MHS institution. Rather than discourses of recovery changing the NHS-MHS, the discursive frameworks, regimes of truths and dominant discourses of the NHS-MHS naturalise a changed meaning of the word recovery.

The absence of a challenge by the social work profession to the NHSFMH vision and rationales of 'effective mental health services', its constructs of 'mental health professionals' and 'multi-disciplinary team', and its lack of recognition for alternative ways of understanding, enabled the NSFMH to differently construct the social worker subject. The policy produced MHSW subject denied arguments that presented social workers as struggling to practice within NHS-MHS multi-disciplinary teams. In 1994, before the launch of the NSFMH, Onyett *et al* published a survey of NHS-MHSs' multi-disciplinary community health teams. This raised several issues in relation to the teams' functioning. They specifically noted the conflicting demands of the social workers' role (Onyett *et al.,* 1994, p.36). In 2006, Evans *et al.* published their findings of a survey of MHSWs, concluding:

> Multi-disciplinary teams are the preferred model of mental health care provision… this study highlights that; the environments in which MHSWs work are associated with job dissatisfaction and poor mental health… workers in these services are over stressed, emotionally exhausted and feel undervalued. (Evans, *et al.,* 2006, p.80).

In 2010, BASW published its policy *Social Work in Multi-Disciplinary Mental Health Teams* in response to the concerns from a significant number of social workers in relation to their experience of working in NHS-MHS CMHTs (BASW, 2010, p.2). The position of BASW was positive about social workers working in NHS-MHS and optimistic about their role. Where social workers had reported poor experiences in the NHS-MHS this was attributed to poor support in their environment. The action needed to according to the paper to support social workers so they could work effectively within CMHT's consisted of two principles and a list of

processes and practices needed to achieve these (see Appendix 3). One of the two principles that was considered necessary was that:

> Health managers must recognise that social work is a profession with its own principles and codes of conduct and unique knowledge and skill set. This knowledge and skill set includes safeguarding, the mental health act, case management and personalisation, but also relates to wider knowledge emanating from research and practice. This includes a high level of understanding of the social model of disability (BASW, 2010, p.16).

Although the tone of the policy was very positive and referred to social workers as valued and respected within NHS-MHS, I considered if this is the standard that was missing and principle that needed adopting; it suggests the problems social workers were voicing in their concerns about working in CMHTs stemmed from health managers not recognising that social work was a profession. This linked directly to my research question: how do MHSWs construct a professional self within NHS-MHS? It also linked to the issues raised in Section 3.10 regarding the complexity of constructing a professional social work self as a MHSW in NHS-MHS.

3.12 Social worker and subject positions within NHS mental health services

Prior to the launch of the NSFMH in 1999, the NHS and Community Care Act 1990 (1990a) set the expectation that people with mental health problems should be supported in the community, and that health and social care services should work together to de-institutionalise care (McCranie, 2011). In this new environment, outside of the hospital setting, professionals worked more independently and attempts were made to coordinate and bring together all the professionals working with a person with mental health problems in the community through a process called the Care Programme Approach (Health Service Circular/Local Authority Circular, 1990) . The policy was updated in 2008 in the Departments of Health's document *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance* (DoH, 2008). This 2008 document sets the rights and expectations of people with mental health problems using NHS-MHS. Everyone has a right to a Care Programme Approach (CPA) assessment, care plan, risk assessment and contingency plan. It constructs the professionals within NHS-MHS as 'The capable workforce' (DoH 2008, p.33) constituted as:

> The Ten Essential Shared Capabilities (ESC) framework, developed in consultation with service users and carers together with practitioners, provides in one overarching statement the essential capabilities required to achieve best practice, for education and training of <u>all</u>[1] staff who work in mental health services. (DoH 2008, p33).

In this extract, a rhetorical device (Pomerantz, 1986) is used to challenge that it is possible for any professional training (such as social work) to produce *best practice in mental health* that is not based on these capabilities. This is a 'truth' that has been endorsed by 'services users and carers', and 'practitioners'

[1] Underlined emphasis from the original text

themselves, so what position is left, other than an unreasonable one, to contest this 'truth'? The subject within these discourses of mental health practice and service is not constituted through professional skills and knowledges but through the collective construct of 'the team': the team provides best practice. The CPA policy takes this further as it introduces 'the care coordinator'. This is not a professional specific role but a generic mental health worker role, not delivering interventions but ensuring their access. The qualifying criterion is having the 'authority to coordinate the delivery of the care plan…it is important that they are able to support people with multiple needs to access the services they need' (DoH 2008, p36).

The CPA process and the role of care coordinators are key constructs in NHS mental health systems and services. I suggest that the roles and subject positions available within these mental health services, produced through these policy discourses, act to de-professionalise social workers who take them up. The role and performative tasks of the CPA subject resonate with the argument made by Flexner almost a hundred years ago (see Section 3.3), that social workers did not exercise unique knowledges and skills in practice, but their skill and practice was to ensure access to professionals '[if] there is illness to be dealt with - the doctor is needed' (Flexner, 1915, p.160). The concerns raised by social workers in Peck & Norman's research (1999) and in the APPGSW report on how social workers are 'deployed' not to use their professional skills but in 'the more limiting role as care coordinator under CPA (APPGSW, 2016, p.4) further support the suggestion of social workers as de-professionalised in this context.

In addition to the position of care coordinator policy, initiatives have also restructured another role, historically profession specific to social workers acting as Approved Social Workers (ASWs) under the 1983 Mental Health Act. The workforce changes linked to the implementation of the NSFMH and launched in the support document *New Ways of Working for Every One* (DoH, 2007), were also reflected in the amendment of the 1983 Mental Health Act in 2007 (2007). The amended Mental Health Act replaced the roles of Approved Social Worker with Approved Mental Health Professional (AMHP) and the role was extended to other professions within mental health, including mental health nurses and occupational therapists (MHA, 2007a). The AMHP role is a regulated role that requires specific training (also regulated), see Appendix 9. The role relates to the assessment and application for detention of a person with mental health problems, thereby depriving them of their liberty, under the appropriate Section of the Mental Health Act. For example, Section 2 for assessment and Section 3 for treatment (MHA, 2007b). The assessment under the Act often takes place when a person is in acute mental health crisis and at risk to themselves or others. Not all social workers choose to train as AMHPs, and not all AMHPs are social workers (some are nurses, occupational therapists and others). However, it is a role that MHSWs who are AMHPs still see as belonging to the social work profession (Morriss, 2014). In Morriss' research, also mentioned in Section 3.5, she found that AMHP work was considered as high status work within NHS-MHS requiring advanced skills and the ability to manage complex situations (Morriss, 2015, p.14). The participants in Morriss' study were all social workers who were qualified AMHPs seconded to work in NHS-MHS. Working as an AMHP involves taking turns on an AMHP duty

rota, with times outside of this spent working in mental health teams as a MHSW. Although social workers reported the AMHP work positively and as exemplifying social work and 'real' social work, Morriss' findings also showed *being* in an NHS mental health team in the general sense of MHSW was challenging. It was difficult to 'make social work visible' and 'reportable' within the team practice (Morriss, 2014, p.283). The social workers struggled to define social work in the NHS-MHS setting; they found their social work practice intangible and they described it as 'innate'. They reported having no clearly defined social work role; their role was without 'clear margins and boundaries', and described what they did as 'filling in gaps left by other professionals' (Morriss, 2014, p.xi).

In this Chapter, I have argued that there are consistent themes throughout the literature, research, reports and policy documents, that working as a MHSW within NHS-MHS is challenging, and can affect the practice, morale and job satisfaction of social workers. This has several possible sources contributing to it as problematic; some relate to social work's sociology as a profession, some relate to the policy constructs of NHS-MHS, for example as multidisciplinary, integrated health and social care teams. Others relate to social work training; how a social worker becomes a MHSW and the clash of culture when social work is placed within constructs of NHS-MHS, without considerations of alternative ways of seeing mental health care and services. In this thesis, I assume a relationship between material events and the meanings constructed around them. These 'meanings' can impact on social workers' practice, constructs of self and effect decisions and actions based on them. Through this research, by understanding how social workers construct their MHSW self and analysis of the talk in the context of the above argued positions, I offer alternative 'meanings' and 'ways of seeing' which can be used by social workers through reflective practice, supervision, appraisal and programmes of education.

Chapter 4 Methodology and methods

4.1 Introduction

I completed the data collection for this research over a period of nine months from February to November 2015 and the process of analysis started from the point of the first interview as part of the piloting process. The following sections will explain how and why I completed this process. Discourse analysis is recognised as a qualitative method within the research process; however, it differs from other qualitative methods in relation to its data source and process of analysis. Therefore, building on the theoretical assumptions outlined in Chapter 2, in this chapter I will clarify the rationale for my methods, including why I selected the participants for this research and how I recruited them, an outline of the resulting sample, the reasons for using a semi-structured interview and how I analysed the data I collected through this process. In the final sections I will also set out how I responded to the ethical matters present in completing this part of the study, and consideration of my position in the research process. My intention is that from reading this chapter it would be possible to have a clear understanding of how I completed the data collection and analysis, and how it could be used to inform other research and knowledge development in the areas of Foucauldian approaches, discourse analysis, the use of Parker's steps and the topic of social workers' subjectivities in NHS-MHS.

At times, I have used the term data in parts of this chapter as this is used within the methodological literature I drew from to inform my discourse analysis research methods and methodology. I have also used the term social worker's *talk* where it is suitable rather than *data* as to be congruent with the qualitative approach taken to understanding the research (Shaw & Gould, 2001). This also conveys the perspective I held when completing the analysis; listening to and recalling the social workers talking in the interview, listening and re-listening to their recorded accounts and reading the transcriptions of the interviews. Additionally, I have used *social worker* or *MHSW* in keeping with the assumptions of their position as 'professionals' within the research process as distinct from a position of a 'subject' of study. I have also used the term *participant* to relay the notion of participatory relationship to me as the researcher and an active position within the research process (Scourfield, 2001).

4.2 The research question and its relationship to the methods

The research question as stated in Section 1.5:

> What discourses do MHSWs draw from to construct their professional selves in the context of (adult) NHS-MHS, and what are the implications for the professional self of the subjectivities and subject positions possible within these discourses?

The methods I chose in response to the research question were based on the theoretical assumptions I argued in Chapter 2 in relation to the nature of reality and knowledge. As mentioned in Section 3.1, research literature using Foucauldian notions and literature in relation to MHSWs' subjectivities was scarce and I extended my terms to include literature that assumed traditional conceptualisation and use of the term 'identity' to increase the scope of the search. The review of the literature in Chapter 3 therefore included research articles, political and professional policy documents that constituted 'social worker professional identity' as a boundaried and definite object. In this thesis, I have assumed that the concept of professional identity is socially constructed and in Sections 2.2 -2.8 I explained that I have used Foucauldian principles to understand the socially constructed sense of professional identity, as a self that is constructed in the form of subjectivities. These are where the person transforms the self into the subject of a particular discourse, through a process of subjectification. My approach to the literature was as a resource to set the research within a wider context of prominent discourses relevant to the research question. Through the concept of subjectivities, I had a method where I could analyse the discourses in the literature, drawing out the subject and subjectivities they produced, and because I had approached the literature using the same methodological concepts, consider any relationships between these and what emerged from the analysis of the talk of the social workers interviewed (see also Section 4.11 Analysing discourses).

My research question had its origins in practical issues and a struggle to reconcile the policy visions of how MHSW worked in integrated practice (see Sections 1.1 and 1.4) and my experience in practice. The gap for me was understanding what, from the perspective of MHSWs, constituted the complexities of being a professional social worker in NHS-MHS. This led me to asking social workers directly about their sense of professional self in NHS-MHS in order to understand how the national discourses that problematised professional social worker identities and the profession of social work were surfacing, or not, within frontline MHSW talk. Dominant within national professional and political discourses of the social work profession was the construction of a failing, maligned and criticised profession, and I wanted to be sensitive to how 'outside constitutions' could be brought to 'inside' constitutions of social workers' subjectivities (Henriques *et al.*, 1998). I also wanted to bring into the research talk about a sense of a professional social worker self from social workers who were not MHSWs working in NHS-MHS, but who had important roles in relation to MHSWs social work practice; for example, Local Authority managers responsible for general standards of practice, and social workers providing professional education and training, due to their role in professional development, management and retention of MHSWs (Clifton & Thorley, 2014). Once I had decided that the data I needed was the talk of social workers, MHSWs and social workers in positions relevant to MHSWs' social work practice, I considered the most appropriate way to obtain the talk of social workers. The following sections explain the rationale and process for the recruitment of the social workers to the research study and the completion of the interviews using a semi-structured approach.

4.3 Situating participants in the research environment

I was aware that the emphasis of discourse analysis is on the talk of participants and its role in producing socially constructed meanings, rather than on the participants as individuals (Wood & Kroger, 2000). I was not seeking an authentic truth of what it means to be a MHSW. Rather my interest is in explication of the conditions of their constructions as a particular kind of discursive subject. I was not anticipating finding and arguing for 'a discourse' of MHSWs, but to explore how discourses were woven by social workers into their professional subjectivities in the context of NHS-MHS. From my review of existing literature, I assumed that social workers would constitute their professional selves from a range of discourses, therefore I selected a method where I could capture sufficient MHSWs' talk of their 'professional selves' for discourse analysis. As explained in Sections 1.1 and 1.4 the issue of the MHSW professional self arose out of understanding social workers within the context of the NHS-MHS, therefore it was important that I recruit participants who were working in this context. Due to the practice origins of the research question I wanted to ensure that the social workers I recruited who had responsibilities as managers, educators or trainers fulfilled these duties as part of the routine work and not a remote theoretical debate.

Research has suggested that social workers constitute their professional selves through their personal selves (Morriss, 2014) and I considered it was important to provide an environment where, if the social worker wanted to refer to this or to possible controversial aspects of their social worker self, they would have a degree of privacy. An interview situation is a very familiar situation for professional social workers; their professional practice is often within the context of 1:1 interviews with the people they are helping, or relatives, and therefore would provide a good way to capture the talk of social workers. It would also allow social workers the maximum opportunity to talk within the time arranged. Social workers are very experienced in interview skills, counselling, supporting people in complex and distressed situations, and advocating and challenging injustices in situations of power imbalance (Thompson, 2009).

Although social workers are professionally skilled and knowledgeable in this area, issues of power imbalances are always present – gender, age, ethnicity, organisational positon within hierarchies (I was Head of Mental Health) and in this case, professional origins (my professional background was as a registered nurse, the majority profession in NHS-MHS) in research interview situations (Scourfield, 2001). I acknowledged that there were issues of a power imbalance between me and the social workers whom I was approaching, recruiting and interviewing. I made all potential recruits aware of my professional positon as a registered mental health nurse, the LA that I worked for and my post there as the Head of Mental Health. I have set out in Section 4.12 the steps that I took to address this issue and I drew from my own professional experience as a psychotherapist, counsellor and my previous research interview experiences. I also respected the skills and practices of the social workers, believing they would discuss any issues arising for them in the interview, or

during their engagement to the research process, and that they would be capable of raising these with me in a confident and professional manner.

4.4 Participant sample size

The methodological literature on the number of participants necessary for robust discourse analysis research states that there is no fixed prerequisite for sample size but what is important is to have a sufficient quantity of quality data to ground the arguments and claims drawn from its analysis (Shaw & Gould, 2001; Shaw *et al.*, 2010). I anticipated that I would need to recruit twelve social workers to the study with a minimum of these being five frontline MHSWs. This was to enable sufficient anonymity of the participants and sufficient data collection. As social workers are very busy with demanding workloads, to improve recruitment and to respect the nature of the working environment I did not ask for more than one hour of their time. This gave time for ensuring informed consent prior to participation, thirty minutes for the interview and then time post interview for any questions that participants may have, or matters of concern they wished to discuss before I left. A sample size of twelve participants would also be manageable within my research resources and scope of the study, and in keeping with recommendations for qualitative methods advised in the research literature where sample sizes may be kept small due to the depth of analysis (Taylor, 2001). Discourse analysis is acknowledged as a rich form of analysis for knowledge production and I found it was also a very time consuming activity for the researcher. It has been argued by Wood & Kroger that a good discourse analytical process takes more time than other research approaches, and needs more time to ensure robust development of arguments and claims (Wood & Kroger, 2000).

4.5 Criteria for participation and recruitment process

The criteria I set for targeting potential MHSWs for involvement included that the individuals needed to be qualified social workers working in the frontline of a NHS mental health service. I did not specify any minimum or maximum length of qualified experience as I was interested in opening up opportunities for discovering MHSWs' subjectivies, not narrowing them by any particular characteristic. The recruitment criteria of the social work managers and educationalist was that they had to be qualified social workers in a role that was relevant to the professional practice of social workers.

Underpinning my approach to recruitment was an intention to work with the social workers transparently on the production of the data and therefore, to be clear regarding the research question and explicit in the focus of the interview questions. I distributed the recruitment pack, with an information sheet about the study, expectations and the terms of volunteering, how to volunteer, a copy of the written consent form, contact details and a copy of the interview schedule with example questions, to the potential recruitment populations (see Appendix 5).

I initially sent the pack by e-mail to all the staff within the workforce that I had responsibility for as Head of Mental Health, and to colleagues within the LA who were social workers with responsibility for the education, training or management of MHSWs. I also sent the pack to a known social work educator contact at a university. The pack was accompanied with the instruction to contact me by phone or e-mail if interested in participating in the research or to pass the pack on to anyone known that may be interested. When I received a response, I followed up through a telephone conversation or e-mail correspondence to enable potential participants the opportunity for further questions and clarification and ensured informed consent. As a result of this recruitment process over a ten-month period during 2014 to 2015, twelve social workers volunteered to participate in the study, all of whom met the selection criteria and no volunteer was rejected. There was one potential volunteer who declined due to their work commitments, but had also questioned during an informal discussion whether as a nurse and non-social worker I could or should complete research on this subject. This provoked considerable thought and self- reflexive analysis throughout this study and I have included consideration of my position as a non-social worker researching this subject in Section 4.14.

4.6 The social workers participating in this research.

The sample for this research study consisted of twelve self-selected social workers. They came from three different geographical shires of England and worked in six different organisations, including NHS-MHS, Universities and Local Authorities. Of the twelve, seven were MHSWs working in the frontline of a NHS mental health service. The majority of adult mental health social care is provided through integrated NHS-MHS, with a minority of Local Authorities providing this through aligned mental health social care teams. All the MHSWs who participated in this research worked in integrated health and social care adult NHS-MHS. The five social workers who were not frontline NHS mental health workers had roles that related to standards of professional social worker practice. Therefore, although I was not looking to compare subjectivities of MHSWs with others by including those who had responsibilities for setting standards of social work practice into the research sample, I increased access to relevant discourses in relation to MHSWs, as training, education and the maintaining of professional social work standards are a crucial part of constituting a professional social worker self. Of the twelve social workers, eight were female and four were male. Ten of the twelve social workers responded to my e-mail request for information regarding their age at the time of interview and the year they qualified as a social worker. I received no response from two social workers and due to the changing nature of mental health services and the geographical distance from the participants it was not possible to confirm whether the two participants had received my e-mail request. Of the ten participants who did respond all were aged between 25 to 65 years old and had been qualified between 5 years and 26 years, with the earliest qualifying as a professional social worker in 1989 and the most recently qualified in 2010.

For the purpose of reporting the analysis of the transcripts I have labelled social workers' extracts using a 4-part identifier: a pseudonym, then either SW (for social worker manager or educator) or MHSW (for mental health social worker). I have used f and m to signify female or male, then finally, where known, I have given how many years they have been qualified as a social worker. There were two participants who did not respond to this question and a dash (–) has been used for these. I have not used age, as this is a small group of social workers and if age is combined with gender it reduces the anonymity of the social worker, and similarly if I specified their geographical area. So, as an example, the label, Sidney (MHSW (m) 15yrs) would mean that this social worker was male, a frontline MHSW within NHS-MHS and had been qualified as a social worker 15 years. Table 1 offers a demographic summary of the participants:

Table 1 Demographic summary of the participants
Total number of participants: 12 social workers
Number of frontline MHSWs: 7
Number of non-MHSWs**:** 5 These were social work lecturers and social worker managers whose responsibilities related to standards of professional social work practice.
From: - 3 geographical shires of England - 6 different organisations. Made up of Universities, Local Authorities and NHS-MHSs
Gender - 8 social workers were female, of which 5 were frontline MHSWs - 4 social workers were male – of which 2 were frontline MHSWs
Age range: Of the 10 responses: - 2 were aged 25 – 35. Both frontline MHSWs - 2 were aged 36 – 45. Both were frontline MHSWs - 2 were aged 46 – 55. Neither were frontline MHSWs - 4 were aged 56 – 65. 1 was a frontline MHSW 2 participants' ages were not determined as they did not respond. Both were frontline MHSWs.
Years qualified as a social worker: - 4 had been qualified between 5 and 11 years. All frontline MHSWs - 6 had been qualified between 20 and 34 years. Of which 1 was a frontline - MHSW 2 participants' years qualified were not determined as they did not respond. One was newly qualified: Julie (MHSW (f) -) and one had qualified before 1990: Barbara (MHSW(f) -).

The collection of personally identifying details was kept to a minimum to maximise anonymity as this was a small sample group working in a small professional network of forums and organisations. For this reason, I have also not provided detailed biographies of participants. Additionally, the research method did not assume causal relationships and the need to scope potential dependencies and variables. Also, it was not focused on researching any specific demographic group of social workers, such as female social workers or social workers of a specific ethnic origin. For example, if feminist discourses surfaced in the talk of the social workers this would form part of the analysis of what discourses social workers drew from to constitute their subjectivities. My research question was not focused on how specific groups of MHSWs, such as females, constituted their subjectivities, although this may be a suitable area of study for future research.

4.7 Semi-structured interviews

I acknowledge that interviews are an uncertain practice, that the position and assumptions of the researcher will impact on the construction of knowledge emergent through this process. Interviewing, narrative and text analysis cannot be absolutely determined prior to completion of the research process (Burman, 1994). I focused on working with these issues rather than attempting to eliminate them. The method used in this study is paradoxical because language in discourse analysis research is both the focus of analysis and the medium for the research process. I was aware of this as a practical challenge when recruiting participants, developing the interview schedule and when using interviews to collect the data (Parker, 1992). I balanced the immediate need to engage through accessible language that may have suggested a particular location in 'truths', with follow up explanations and information that showed the language used situated more within the study's theoretical approach of a post-modern, post structuralist, socially constructed understanding. For example, to communicate the project information to potential participants I used the more familiar and accessible language of 'identity', such as in the example prompt interview questions (see Appendix 5), rather than the research terms of 'subjectivities' and 'subject positions'. I used the term discourses analysis and made clear my assumption that the term 'identity' had several meanings and that a social worker may have many 'identities', and offered to answer any questions if anyone wanted this clarified.

The paradox of language in interviews is that by using certain phrases or words I could be inviting or privileging particular discourses from the participants, possibly outside of my awareness. In this context, it is possible to see the interview as having the same discursive practices as any social event and the transcribed texts as socially constructed elements of these events. From this perspective, the interview process is seen as any face to face conversation with power plays and calls to accepted and resisted subjectivities by both participants, recognising the researcher's embedded position within the interaction (Kvale, 1996; Scourfield, 2001). Although the researcher is always co-constructing as meanings are formed, it was important that I remained aware through ongoing reflexivity of this issue and to allow 'space' for the participants' meanings, interpretations and questions during the recruitment process and interviews. Therefore, I kept questions

open and I circulated example questions before the interview to enable the participants to have some control over what they spoke of in the interview.

Parker (1992) states that within this paradox that semi- structured interviews are preferable to structured interviews, as they enable the researcher to be absorbed further into the 'life world' of the interviewee. He argues that an interview in qualitative research is always semi-structured because it invariably includes the participants' abilities to refuse and resist what a researcher wants to happen (Parker, 2005, p.53). My use of semi-structured interviews enabled the opportunity for social workers to talk freely and consequently provided a considerable amount of data for analysis. I considered that MHSW subjectivities would be diverse, and that focus groups or naturally occurring talk such as within social work forums, would be likely to limit the range of discourses surfacing due to the limits of space for each social worker to talk of their identity, or that talk of MHSW identity may have arisen only indirectly or not at all. I was not trying to surface a dominant discourse or competing discourses within social worker groups, but was keen to enable each social worker to talk about their professional selves sufficiently to reveal patterns and discourses more freely than would have been likely under the direct gaze of other professional MHSWs. Holding individual semi-structured interviews enabled the social worker greater opportunity for reflection and consideration of their identity construction. I reasoned that discussing a contested and personally drawn professional identity, as argued earlier, would require a safe and unpressured environment. The individual interviews provided some control over pace and focus, and a more personal understanding of the research question for the social workers who took part. The intention was that this would make sense to participants, give them the most time to speak and provide text for analysis, provide the opportunity to sensitively follow up on issues raised, capture unexpected contributions, and to tailor prompts in the moment. This would not have been possible within questionnaire approaches, structured interviews or the use of focus groups.

When I designed the interview and interview process, I considered not only the theoretical assumptions underlying the research question but also assumptions underlying the notions of interviewing that may have been out of my awareness (Roulston, 2010). This included, what kinds of research questions are possible from this perspective? This meant challenging some interest I had that was more from a perspective of personal curiosity than that of research inquiry. I considered the issues that might arise in analysis due to my theoretical assumptions, and that I chose to use a formally arranged and prompted situation to capture social workers' talk, in contrast to naturally occurring occasions, and the criticisms that exist in using semi-structured interviews in discourse analysis. In this research, I understood the interview to be an open and flexible vehicle to gather the relevant data that was likely to be complex and unpredictable in nature (Burman, 1994). I constructed an interview schedule, with example questions (Appendix 5), which were open and flexible and which I circulated prior to the interview. I intended this schedule to serve as a prompt to stimulating the social workers to talk about themselves as social workers and as MHSWs. It was important that I gave space to the social workers to bring into the talk the discourses they were drawing from, and that

I did not introduce or prioritise any one discourse. Therefore, the questions covered a range of possible prompt areas and were open in nature.

I anticipated a need for flexibility when completing the research process and understood that modifications may be required to the interview schedule and plan. When interviewing, I started by asking the social workers to select which question they would like to answer or if they had an area they wished to talk about that was not covered by the list. If the social worker preferred that I selected the question to start the interview I started with asking how they came to train as a social worker. Although the schedule was designed around MHSWs the same schedule was used for all participants because the range was wide enough to be relevant to those not working in the field of mental health social work, participants could introduce their own responses not included in the schedule, and it kept the focus on mental health social work rather than broader social work issues less closely related to the research question.

Although experienced as an interviewer I recognised I was still developing my research interview skills and experience, and referred to Roulston's guidance on quality in interviewing (Roulston, 2010). I also used Kvale's (1996) quality criteria as a way of stepping outside of the interview and to evaluate the event without complacency or bias. These criteria included the extent of spontaneous, rich, specific, and relevant answers from the interviewee, the degree to which the interviewer follows up and clarifies the meanings of the relevant aspects of the answers, and to which the interviewer attempts to verify his or her interpretations of the subjects' answers during the interview (Kvale, 1996, p.145). I found it interesting that when using these criteria to evaluate the quality of the interviews I was very reassured how well these had been achieved, which I link to the nature of who I was interviewing (social workers) and my professional skills. What was a success due to my experience of interviewing became a challenge highlighting my inexperience as a researcher, as the wealth of data made me very conscious of, as a novice researcher, the daunting task of robust and credible discourse analysis.

4.8 Piloting the interview

I piloted the interview schedule and planned the interview process with a colleague who was a qualified social worker and a peer with whom I worked in the LA. They also led the adult social care research approvals process. I therefore thought them well equipped to recognise and challenge any issues arising from the perspective of a social worker taking part in my research. I informed my colleague of the research project, they received the full research proposal, and I gave them the recruitment pack prior to obtaining their written consent. As peers and colleagues, we had worked well together on other projects and I trusted they would give me candid and informed feedback on the experience and process of the interview. I could use this feedback to change any parts of the interview and evaluate its suitability and effectiveness in gathering social worker talk. It was also a useful source of evaluating how rich the data would be in thirty minutes of

interview and provide a basis to judge whether the proposed number of interviews would be sufficient to provide the data required for analysis. The feedback from my colleague was that:

- The information was simple and clear
- The focus of the interview was very topical and popular amongst social workers
- The process had been sufficiently transparent with opportunity to ask questions and gain further information made clear

The resulting talk from the interview provided considerable and rich data that was suitable for analysis and discourse recognition. With my colleague's permission, I included the talk from this pilot interview in the overall data collection and analysis (informed written consent was obtained for this).

4.9 Conducting the interviews

Before proceeding to the interview, I checked that participants had received all the details contained within the recruitment pack, that they understood this information, and asked whether there were any questions. I repeated details of my student, job and professional status and reminded each participant of the research focus and purpose and the voluntary nature of participating. I emphasised that if they had any questions or felt uncomfortable at any point of the interview to let me know as we could pause or stop at any time at their request. Of the five social workers who were managers or educationalists, I interviewed four in their place of work (university, LA and mental health services setting), and one in my place of work (a LA building). Of the seven MHSWs, I interviewed six in their place of work, all of which were known as NHS-MHS buildings. One MHSW requested to be interviewed in my place of work. On visiting MHSWs in their place of work I observed that the NHS-MHS setting offered challenges to a social work construction of a professional self as the environment spoke to a medical discourse of mental health. There were posters with language and ways of speaking that called to a 'clinical' professional subject position, with words and images producing positions of 'patient' and notions of 'treatment'. I considered this environment also offered the participants the opportunity to constitute their professional selves through NHS staff member subjectivities. Although I was not discursively analysing the environment as part of this research I was aware of its importance and that it was a part of discourses and subjectivity construction (Burman, 2003). I believe this would have been a rich source of data for discourse analysis if it had been possible to bring it into the scope of this study, and noted the possibility of including this in some future study in this area.

All of the interviews were digitally recorded and lasted between 29 minutes and 49 minutes. This time duration worked well for the social workers whose usual appointment schedules worked to hour engagements. Prompt and example questions were used as I sustained the conversation and clarified some of the phrases used that were ambiguous or open to many interpretations. I noted that this contrasted with many of the conversations I had been part of personally, outside the researcher role, on topics such as the

state of social work in mental health or what social work should be, where I had given views, taken out more of the space for conversation or been more challenging.

4.10 Transcription

I considered the transcription of the digitally recorded interviews as a significant part of the research process as it raised several questions and decisions for the researcher (McLellan *et al.*, 2003). I was conscious of the power position I had at this point and how I was in a position of trust in relation to the verbal exchange that occurred within the interviews with each social worker, and how I selected what and how this was included in the transcript (Riley *et al.*, 2003). I chose to transcribe the digital recordings myself as this benefited the robustness of the research (Parker, 2005). I wanted to include listening to the interviews as part of the analytical process to support the text analysis. The text can never fully capture all that takes place in an interview (Kvale, 1996) and listening to the recordings added subtleties of tone, intention and prompted recall of the interchange that enriched the text and enhanced its quality as 'talk' (Riley *et al.*, 2003). Although I was aware that there are very reliable and experienced transcription services, all transcription involves translating from one form of language to another and can shape what is communicated to the reader. I wanted to be aware of the micro decisions that would be taking place, including the compromises or adjustments. If the recordings had been transcribed by someone else these nuances would be lost and my confidence in the text, as anchored in the interview, would be reduced (Parker, 2005).

When transcribing I included the contributions and questions that I made during the interview, acknowledging they were part of the construction of the social worker responses and including me in the process. I also had to decide the degree of marks that I would use to represent meanings conveyed through tone or nonverbal responses, such as laughter, and level of detail in the attempts to translate a verbatim account. This was relevant not only to the analysis but also to presenting extracts from the transcripts within this thesis. Views range on how stringently the researcher details utterances through marks and symbols by both the interviewer and interviewee, with argument for the importance of this detail to be included to ensure that subtle elements are not missed. Also, it enables the reader to make an evaluation and protects the extracts from embedding the researcher's own theoretical assumptions. For this research, I drew from Parker's guidance on transcribing and the use of marks and symbols to represent the recorded account (Parker, 2005, p.65). See details of these within Appendix 6. This process of transcription, transforming the social workers' talk into text, began my journey as researcher through Parker's steps. His first criteria states that discourses are realised in texts (Parker, 1992, p.6; Parker, 1994, p.96). The following sections explain how I used Parker and completed the broader process of discourse analysis.

4.11 Analysing discourses

This section builds on the theoretical understandings set out in Chapter 2 by detailing how I applied them to analysis of the data. Foucault (1974), wanted his books to be used as a tool box where researchers could find tools to use however they wished. He emphasised his intention that his work was to be in the hands of those who impact 'on the real' stating, 'I write for users, not readers' (O'Farrell, 2005, p.50). Foucault's work does not provide a clear and unambiguous approach to completing research and Foucault did not expect his work to be mechanistically applied (Foucault, 1978). Therefore, by using O'Farrell's (2005) critique of applying Foucault's work, I had the benefit of a consistent source of reference for interpretation. Initially I found the practical application of Foucault's theoretical assumptions a mixture of excitement at its potential for understanding and responding to the research question, but also challenging due to what seemed to be its freedom of interpretation and complex abstract nature. As a novice discourse analytical researcher I wanted a reference point to anchor the 'doing of discourse analysis' and to monitor for any potential drift to other approaches. As Parker comments the 'feelings of muddle and confusion may overwhelm the researcher approaching the text for the first time' (Parker, 1994, p.96). Although well supported by a skilled and experienced team, I was vulnerable to the failings of researchers using Foucauldian approaches outlined earlier in Section 2.9 and of 'not doing' discourse analysis (Burman, 2003; Garrity, 2010).

My engagement with the methodological literature led to using Parker's steps to discourse analysis to support the process of analysis. I used several resources to develop an understanding of applying this approach (Parker, 1992; Burman & Parker, 1993; Parker, 1994; Parker, 1999; Parker, 2005) and mainly drew on two specific accounts for the steps to discourse analysis (Parker, 1992; Parker, 1994); see Appendix 7. I selected Parker's steps, because in contrast to interpretive repertoires, I could use them with Foucauldian concepts of discourses, regimes of truths, the discursive nature and social practices of institutions, subjectivity and subjectification (Edley, 2001). Parker (2002) describes the differences in the two discursive approaches to discourse analysis as their emergence from two different theoretical positions. Parker's approach to discourse analysis is Foucauldian and emerges from the work of Michel Foucault, whereas the interpretive repertoires approach to discourse analysis originates from social psychology and the study of the sociology of scientific knowledge (Parker, 2002, p.127). Parker's focus is more open to everyday life rather than specific phrases or turns of speech and the close analysis of the language of the text found in interpretive repertoires (Ballinger & Payne, 2000, p.568). Parker's approach also gives space in the analytical process for using understandings from contemporary theories with their origins in Foucault's ideas that argue new understandings and interpretations. For example, in theories of gender, when engaging with Foucauldian notions of production of the real, the naturalised constructs of the female subject and subjectivities (Butler, 2007; Salih & Butler, 2004).

Parker's steps provided a supportive but not restrictive process that I returned to whenever I felt adrift or overwhelmed by choice, to sustain the focus of analysis. When I first started the process of analysis, as part of completing the pilot described in Section 4.8, I worked slowly through each step with the books at my side (Parker, 1992; Parker, 1994), re-reading the example given and returning to the transcript I was analysing with the examples in mind (Parker, 1994). The analysis of this transcript was completed after a week of focused work, and generated a considerable amount of information and learning. My skills of analysis were further developed by reading other examples of completed Foucauldian discourse analysis (for example, Carabine, 2001; Alldred & Burman, 2005), reading Foucault's works directly (for example Foucault, 1978; Foucault, 1969; Foucault, 1984), reading about Foucault's work (Rabinow, 1984; Macey, 1993) and about using his work in research (O'Farrell, 2005). Once I was more familiar and confident with them I used the steps in different orders and combinations (Parker, 1992). I read the texts with several questions in mind - what type of social worker was produced by the text? what could be said when constituting a MHSW as a professional self? and what was natural and taken for granted about social work in NHS-MHS? Finally, I reread the transcripts without explicitly following the steps, as discourses became more 'visible', including the discursive elements, subjectivities, and subject positioning, leading to 'seeing' the possible subject positions produced through the social workers talk.

An important principle of Foucault's approach is that 'objects' are formed, and the researcher's work is to find ways to throw light on objects so they become visible (Foucault, 1969, p.49). I wanted to throw light on the constitued object of 'MHSW' within NHS-MHS, as the social workers' talk constructed their professional selves. Using Parker's description of the object as the subject that speaks, and that the sense of self as realised through discourses which spaces make available for particular types of self to step in (Parker, 1992, p.9), I started analysing the transcripts by systematically reading through each one and highlighting 'objects' and 'subjects'. Terms can be objects or subjects in text; in Parker's example, he identifies 'professionals' as an object, a noun in his text and then as subject, a type of person with specific rights and ways to speak in the text. I then looked for the 'ways of speaking' and rules of what could and could not be said in relation to these (Parker, 1992, p.8), This process revealed not only the objects and subjects but also relationships and shifts in discourses. I found objects, such as 'team', 'medication', 'assessment' and subjects, such as 'patient', 'care coordinator', 'manager'. I looked for how the objects were formed through the talk and what rules were called into being. I looked for links between the 'object' and where the social worker was drawing from to produce it and the 'truths' assumed.

I approached the analysis of the social workers' talk from the perspective of Foucault's principle that the researcher seeks to make visible the conditions and contingencies underlying truths to reveal them not only as the products of discourse but also that of power (Foucault, 1976). Although each discourse operates as truthful, what I had to look for was what benefits from *that* discourse's particular *truth* claims, and what power basis that *truth* ensures and endorses? (Hook, 2001). I focused on how subjects operated in the text

as a useful way to explore the different rights to speak produced in the social workers talk and the positions the subjects could take and their positional relationships (Parker, 1994). Weedon argues that the political significance of post structuralist constructs of subjectivity (in contrast to the subject as sovereign, boundaried and unique) is that it opens up the subject to change as the product of culture and society (Weedon, 1997, p.32). In the analysis of the social workers talk, I consider how the subject and the subjectivities of the MHSWs were produced within the culture and the society of the NHS-MHS. I also used this understanding to see the different patterns of meanings used by the social worker to construct their professional selves in their interview, and to see subjectivities within different discourses, including what action was taken on the self to produce different subjects (such as social worker, MHSW, care coordinator).

I considered the order of the discourses and power knowledges (medical knowledges were privileged above social knowledges of mental health), and the discursive effects on the ordering and the privileging of discourses in the social workers' text. By analysing how and what formed the objects and the subjects, I wanted an understanding of the rules, limitations and relationships that were in operation, that had a discursive and power effect in the construction of social workers' professional selves. For example, who legitimised and constituted the subject positions of 'MHSW' within the social practices of the institutional context, the different rights to speak - team manager, doctor, patient, care coordinator, social worker, AMHP - what space the social worker could take and what they could say, what rules were assumed. What were the different rights that each person, subject, subject position had – who could pronounce, construct and legitimise the nature and presence of urgency, who made decisions? (Parker, 1994, p.98). To increase the visibility of the naturalised and hidden assumptions underpinning the truths of the talk, I used Parker's steps 6, 8 and 9 to consider how the ways of speaking about being a MHSW in the NHS-MHS would respond if I challenged the logic and conclusions with alternatives.

To illustrate, if I suggested during a NHS-MHS team's discussion that a person's housing was a priority, not their diagnosis and that a doctor may follow this up with the family. What subject would this produce in the context of the discursive rules and regulations found in the discourses of MHSWs' talk? In scientific discursive frames and bio-medical discourses of mental health, I suggest this would be situated as a non-professional subject, constituted through ignorance of mental illness and how this gives meanings to professional practice within the NHS-MHS systems. Forming a relational subject position within the teams' discourses to subjects constituted as 'real' professionals, and making possible meanings of this suggestion as irrelevant and wasting the 'real' professionals' time? The discursive rules mentioned here are linked to the operation of power through regimes of truths and knowledges ordering of discourses (Foucault, 1981). I looked for how the discourses were both constituted by, and reproduced, the social system, through selection, exclusion and domination of truths seen in the social workers talk of their practice within the NHS multi-disciplinary mental health teams.

I acknowledged that there are shifts in what is legitimate knowledge and what are the truths. Foucault described this as the history of truth:

> …that varies according to the range of objects to be known, the functions and positions of the knowing subject, and the material, technical, and instrumental investments of knowledge (Foucault,1981, p.55).

I applied the definition of objects as the things that the discourse refers to. In contrast, I applied the definition of subjects as who speaks, write, hears or reads about objects, to the process of analysis (Parker, 1992). I considered the discourses and the subjects produced in the MHSWs' talk in the context of the research and policy literature in Chapter 3. I looked for any contrasts between the MHSWs' talk and constructions of MHSW in political and professional discourses at the time when NHS-MHS teams emerged in the late 1990's (DoH, 1998; DoH, 2002; DoH, 2007a). This was when the vision of an ideal NHS-MHS was constituted through multi-disciplinary CMHTs, and MHSWs were constructed as change agents broadening understanding and access to 'social' knowledges of people and mental health.

Through analysis I came to 'see' patterns and discourses within the social workers' talk, and the discursive language producing the subject positions constructing the sense of professional self in the NHS mental health setting. I searched for patterns in the talk and for contradictions in producing meanings and realities (Parker, 2002, p.123) and the relationship of these meanings with other patterns meanings and constructs. I looked for why that construct was supported, what conditions called those subjectivities into existence and what constructed the social domain, alongside the space that set out the subjectivities that were and were not possible (Henriques *et al*, 1998).

In Chapter 2 I discussed the theoretical assumptions of how subjectivities and subject positions were understood and applied these when analysing the social workers' talk. I assumed that subjectivities and subject positions could be self-contradictory in nature, and would change and vary moment by moment, situation by situation, depending on what was possible in the space and logics of discourses and discursive practices. When I read the transcript of each social worker's talk I was looking for how they acted on 'the self as subject', through intersecting and weaving discourses, subjects and subject positions, to produce meanings and constructions of 'mental health NHS services' and a sense of professional self in the NHS mental health setting. Analysis continued by looking for patterns associated with the process of subjectification within the discourses and the 'subjectivities' that could be seen. I assumed that the social worker subjectivities would be both suppressed and resisted, and that a level of agency would also be possible in the social workers' subjectivity construction. I assumed suppression and dominance effects on subjectivity construction would both be out of social workers' awareness and that some agency could be exercised when choices were possible. I explored how some discourses were resisted and how others were woven to form the possible subject positions (Foucault, 1984; Fawcett & Featherstone, 2000) - with some positions, more than others, resembling ideals of the social workers' self as professional MHSW subject.

From studying the notes made through the process of analysis as described above, the predominant themes, patterns and productive talk emerged and I selected these for presentation in Chapter 5 Analysis and Interpretation.

4.12 Ethical considerations

Throughout this project, I have maintained a steady focus on ethics, and adhered to my professional nursing code of practice and behaviour under my registration as a nurse with the Nursing and Midwifery Council (2015). The practical detail of how I considered ethics when conducting this research can be found in Appendix 8. I was particularly sensitive to power issues and how they might potentially impact on the relationship between me, as a Head of Mental Health and the social workers that I approached, particularly those who were within my sphere of responsibility and employed by the LA where I held my post. In Sections 4.3 - 4.5, I have given details of the participants, recruitment and interviews and introduced the potential power issues (see also Appendix 8, Issue 5). When I recruited and interviewed social workers, I emphasised that choosing to participate or not to participate would not impact on any relationship we had outside of the research. To ensure that social workers could safely voice any concerns about my conduct, I gave them the name and contact details of the Principle Social Worker within my employing LA. He routinely attended the social worker forums so social workers could also approach him discretely within these meetings. His responsibility was for the standards of practice and fairness of all research projects undertaken by the Adult Social Care directorate within the LA, and he was able to approach me confidentially, both informally or formally, if any concerns or questions were raised.

I was also aware that using interviews for discourse analysis has been challenged from an ethical perspective by Hammersley (2014), who raises the discrepancy between the interviewees' assumptions and expectations about how the data will feature in the research, and how it is used by the researcher. Hammersley suggests this results in a subtle form of deception by the researcher, and questions how informed the consent is when given by those being interviewed. In qualitative research, this introduces a consistent problem around *how informed* consent can really be. In my work, I realised participants would have varying levels of knowledge and assumptions in relation to the methodology I used and the conceptual approach that I was taking to the topic of this research. Taylor (2014) states this would be more a matter of comprehension than deceit. The active engagement in research, as reader or researcher is seen as a fundamental aspect of social workers' professional practice (Webber, 2013) and in an examination of the most influential and highly cited publications in social work disciplinary journals, Hodge *et al*, (2012) found that evidence based practice and social work research played a particularly important role in the professional discourses of social workers. Additionally, Foucauldian approaches to social work and the use of discourse analysis is a familiar and valued approach to understanding social work practice (Chambon *et al.,* 1999; Healey, 2005; Fook, 2012; Gray & Webb, 2013). Therefore, when completing the research process I followed steps to enable particpants to be

as informed as possible, to have the opportunity to ask clarifying questions and receive further explanations in relation to any aspects of the research. I found that the social workers considered their involvement in this research a part of their professional practice.

4.13 Researcher position in relation to the analysis of data

Foucault argued that the purpose of research was a matter of shaking this false self-evidence, of demonstrating its precariousness, of making visible not its arbitrariness but its complex interconnection with multiplicity of historic processes (Foucault, 1978, p.225). With the many sources of pressure on MHSWs practice within rapidly and continually changing national frameworks, media opinion and priorities for social work practice within services, this origin of research purpose matched well with the origins of the research question and its practical place within workforce and service development. As the researcher, I took the role, argued by Hook as a methodological imperative when using a Foucauldian approach, of an unrelenting challenger of all rationales, explanations and statements that are self-validated on the basis of their proximity to an adopted truth; such as, ensuring medication adherence is more of a priority in mental health care than resolving a notice for eviction for a person with psychosis. The methodological task was to replace the 'true' statement with the conditions that demonstrated how what counted as 'the truth' was produced through and by discourses, and the power that truth held discursively and acted on the real. This enabled an exploration of the conditions of possibility; what was possible and what was not in relation to social workers' subjectivities, including the pervasive power-knowledge complexity (Hook, 2001, p.6). What was particularly pertinent was Foucault's notion that the transformation of institutions only happened through a critique of the real, and that, for example, social workers working in prisons should use his research, not to be told what should be done, but to think, to resist and to refuse what is (Foucault, 1978, p.236). Foucault argued that the eroding of the 'self-evident' and 'commonplaces' about 'madnesses' and 'normality' had the effect that certain phrases could not be said 'so lightly', acts could no longer be performed unhesitatingly, and that the shifting of sensibilities and tolerances had impact on real effects.

4.14 Researcher position in relation to the production of knowledges

As mentioned earlier in the introduction as researcher I had an insider and outsider position within the research process (Kanuha, 2000; Corbin-Dwyer & Buckle, 2009). I was not a qualified social worker; I was a registered mental health nurse with experience as a community mental health nurse within NHS community mental health teams. These factors had relevance to the focus in this research. In addition, my interest in social worker identity was not from a 'professional' perspective but linked to my experiences as a senior manager as a LA's Head of Service for mental health. Morriss (2014) had argued that her position as a researcher who was a social worker helped connect to social work knowledges that were intangible, but which she could understand in the interview process through the shared connection of 'being a social worker' (Morriss, 2014). Although all the social workers that wanted to take part in the research were

accepted as participants, one potential candidate that I approached with the recruitment pack asked whether it was possible for me to complete research on social worker professional identity without being a social worker. This person later declined to volunteer due to time commitments (Section 4.5). I also knew through the literature that social workers in mental health have constructed the social worker identity through a process of 'nurse as other' (Morriss, 2014). Following discussion with Morriss (2017) regarding her research findings and the issue of a non- social worker completing social work research, I concluded that as a mental health nurse I was a professional mental health peer, and the nature of mental health social work in the NHS mental health setting is as part of a multi-disciplinary team where most team colleagues are nurses. Research has suggested that social workers had difficulty articulating what they do and making their work visible to their non-social worker team members (Morriss, 2016) and that outsider researchers can bring new ways of seeing, what may have become unseen due to familiarity and a perceived naturalness to those for whom it is an everyday experience (Kanuha, 2000; Corbin-Dwyer & Buckle, 2009). Also, that health colleagues and managers do not understand mental health social work or recognise the professional skills and knowledge of MHSWs within the context of multidisciplinary team working (APPGSW, 2016). Therefore a research contribution and new knowledge from a non-social worker provides a useful addition to perspectives and understandings of mental health social work.

I was aware of potential subjectivities I could produce and construct in the interview dynamic. These included those drawing on my subjectivity as a female, a LA manager, a registered mental health nurse, a community mental health nurse, and as British and white. Also, my age which was sometimes similar to those I was interviewing and sometimes of a different generation. These all suggest that some talk will contain ways of understanding that seem natural to me and some that I would find less familiar or challenging; this could impact on the way I understand the social workers' responses and what I 'recognise' in their talk. Parker (2005) suggests the researcher needs to consider the impact of agreeing or disagreeing with what participants said, whether during the interview I had validated or sympathised with their talk and therefore subtly influenced the 'co-construction' of meanings during the interview. Considering this, I became aware of a strength I brought to the process through my training and experience as a counsellor and psychotherapist, and my work on values-based practice (Woodbridge & Fulford, 2004). This had made me open to working with difference and being in situations where I might agree or disagree but kept this open to possibilities that this was due to differences of perspective and understanding of the issues.

However, as Burman has stated, 'Put simply, there is no way of avoiding some kind of position' (Burman, 2003, p.3). In order to reduce the potential for overshadowing the co-construction of new knowledge with personal opinion and pre-held biases, I have taken a critically reflexive approach to my interpretation and analysis of the literature and the social workers' talk (Finley & Gough, 2003). I have used supervision and an ongoing sharing of my ideas and understandings of the research with my network of MHSW professionals, to open these up to challenge and revision.

Chapter 5 Analysis

5.1 Introduction

This Chapter presents the outcome from the application of the theoretical assumptions and methodology set out in Chapters 2 and 4, and my exploration of how the MHSWs' sense of a professional self was subjectively formed from the discourses they were immersed and actively engaged in, and how the MHSWs were formed and formed themselves as the subject in the discourses available to them (Dent & Whitehead, 2002). Similar to the literature reviewed in Chapter 3, the Analysis Chapter has a considerable focus on the construction of professional social worker selves. This is because the central subject position and reference point for subjectification (see Section 2.7) of the mental health social workers' construction of a professional self was that of social worker. By providing the analysis of this constructed professional self, often drawn from the social worker original social work training, it is more possible to 'see' the impact of discourses and the social practices within NHS-MHS on MHSWs' construction of their professional selves. This also includes seeing the positioning effects, subject positions and subjectivies available within the discursive frames of the institutional context. All of the MHSW's talk suggested that if a hierarchy of meanings existed within what they drew from to construct their professional selves, the self as social worker was a priority, was primary and the most coherent subjectivity and subject position. Sections 5.2 – 5.5 present the analysis relevant to this subject position and the nature of its construction as a professional. Section 5.6 presents the analysis of MHSW's talk reflecting the impact of discourses of generic and specialist social work on the construction of a professional social worker self in NHS-MHS. Section 5.7 explores the construction of a MHSW self within the subjectivies and subject positions available in the discursive frames and social practices of the NHS-MHSs. Section 5.8 summarises the typology of subject positions, suggested through my analysis of the MHSW's talk, that were available to MHSWs within the social practices and discursive frame of the NHS-MHSs.

In contrast to the literature presented in Chapter 3 I did not find that the social workers interviewed drew from discourses of a profession in crisis when constituting their professional selves. I did observe how construction of a professional self could draw from how social work was constituted negatively in the media. Also, resonating with arguments previously discussed relating to social work as a profession, I became aware of frequent patterns within the talk of the social workers interviewed; such as that of a professional self constituted through a personal self interwoven with discourses of social work's professional values base, and the production of the professional social worker subject, through social knowledges drawn from programmes of learning when originally qualifying as a social worker. Within the MHSWs' talk I saw patterns drawn from discourses relating to 'multi-disciplinary team working', 'bio-medical discourse of mental health' and 'NHS managerial discourses'. This resonated with the research literature on the impact and understandings of integrated NHS mental health services (Bailey & Liyanage, 2012), the role of professionals within multi-disciplinary teams (Liyanage, 2012) and the MHSW's and the Approved Mental Health Professional role in

NHS-MHS (Morriss, 2014; Morriss, 2015). The following sections set out these findings that emerged from the discourse analytical process I undertook, and the concluding Section 5.8 summarises the typology of subject positions I suggest as a result of this analysis.

5.2 Changeable and indefinable does not mean crisis, it means social work

The most prominent discourse in the literature constituted social work as a problematised profession in crisis (Asquith *et al.,* 2005; Beddoe, 2013; Moriarty *et al.*, 2015), with social work presented as ambiguous, challenged, ill-defined and blurred with other professions (Brown *et al.,* 2000), constructed through an international history of disputes and struggles for professionalism (Hugman, 2009; Gitterman, 2014). In 2005, a report was published on a major literature review commissioned to understand the role of social work. This stated that:

> It is argued in this review that the 'crisis' in social work has to be understood in a broad context of professional, organisational, social and political changes since the 1960s (Asquith *et al.,* 2005, p.2).

Baxter placed constituting professional *identity* within a changing environment, formed of policy turbulence, increased pace of change and economic austerity where public sector professionals are subject to multifarious challenges compounded by uncertainty (Baxter, 2011). Therefore, key elements that produce that crisis are that what social work is and what social workers do is unclear, ill-defined, and the subject of frequent change. When analysing the talk of the social workers the difficulty with defining social work, and what social workers do, and social work's changing nature were present but not as constituting professional crisis, but appeared naturalised as what social work is and what it means to be a social worker.

In the literature analysed in sections 3.3, 3.4 and 3.7, one of the 'logics' constructing social work as in 'crisis' was based on a relationship between a profession that cannot define itself or articulate itself, and one that is under threat of its existence as a result (Moriarty *et al.*, 2015). Social work is portrayed as a profession which is weak and in urgent need to define itself so social workers can practice effectively and survive the difficult environments in which they work (Baxter, 2011). One of the key points made in a systematic review of roles and issues within social work in England was that the definition of social work was contested and controversial (Moriarty *et al.*, 2015, p.3).

However, in the talk of the social workers who participated in this study it was the 'nature' of 'being a social worker' and of social work practice itself that 'meant' it was unexplainable. *Not* being understood by others was therefore part of constructing the self as a social worker and what you did as social work. The extract from Mary shares this as the normalised position of her being a social worker:

> Mary (MHSW (f) 9yrs): I've asked any number of people about what they think social workers do, sometimes they say 'errrr' which is a noise I'm familiar with.

Here, in suggesting she often hears an un-worded response *'errrr'*, Mary reiterates the view that social work is a profession which is poorly understood. She uses the generalisation that 'any number of people' could be asked to underscore this as a common response. Mary can construct herself as a social worker because social work is not a profession that can be articulated, and therefore possible within a social construction where '*errrr'* is a noise she is familiar with from others.

I saw the discourse of 'not knowing what social workers did' constituting the social worker as professional subjects, in the social workers' accounts of how they came into social work which was from a 'not knowing' subject position. I noticed this often included weaving a personal self with a professional social worker self. A construction of professional contrary, in form and nature, to traditional constructs of profession and professional knowledge seen in Section 3.2. Traditional frames of what is a profession set the knowledges that constitute a profession separate to and independent of a personal self. Stuart's use of, 'like lots of people' in the next extract is similar to Mary's, 'any number of people', in the previous one. They produce a naturalised construct of social work as a profession that is unknown by those who are not social workers. Stuart also brings together the personal position of what he wanted to do and his personal circumstance with the doing of 'social work' to construct his social worker self.

> Stuart (SW (m) 26 yrs.): like lots of people when you were at school you didn't know anything about social work, you never heard of social workers. But I had this idea of wanting to work with people and help people, do something. So, I went to [--] university and I did a degree in social policy [--] graduated [--] There were hardly any jobs anywhere so I became a residential social worker because, you know, the hands-on bit. In all honesty because it was residential care they gave you somewhere to live so that meant I didn't have to go home and live with my parents.

Stuart traces his journey of forming his professional social worker self as moving from one of the 'people' not knowing social work and the 'you never heard of social workers', through personal 'desires' to 'help people, do something' and his personal circumstances. Also, Stuart's talk places the 'becoming' a social worker not after completing the university degree but when he took up the job of residential social worker doing 'the hands-on bit'.

Using one of Parker's steps to revealing naturalised assumptions (see Appendix 7, Step 8), I considered if it would be possible to make these statements about other professions. I considered that to say 'like lots of people I didn't know anything about doctors or nursing, I had never heard of doctors or nurses' would be an unnatural way of speaking for those professional discourses but for discourses of social work it was natural within subjectivities.

I observed the talk of 'social work' as unknown and unknowable to non-social workers was seen in the social workers' accounts of how they entered the profession. Finding their way into being a professional social worker was often through accidental routes and through the prompts of others. Discovery was linked to an aspect of the personal self in search of expression and an opportunity where this could be constructed within

a professional self. This places social work within constructs of 'vocation' where there is a calling to serve and care, and association with the extension of a woman's role and charitable duties of the middle classes (Abbott & Meerabeau, 1998).

The following extracts from Stella, John, Sarah, and Julie invite the understanding, not only of social work, but also the path to becoming a social worker as naturally circuitous and one of discovering social work as a profession. A profession where being a social worker is found and where there is no preformed notion of what constitutes the professional or the profession, such as playing hospitals and doctors and nurses in childhood, to bring to notions of being a social worker. This can be seen in the following extracts when participants were asked, how did you come to be a social worker?

> Stella (MHSW (f) 26 yrs.): I didn't really know what I wanted to do when I left school. (I) drifted into teaching came out drifted into banking. Found I enjoyed helping people rather than the financial side of it. Started doing voluntary work with probation [--] then went to work as an unqualified social worker.

Stella 'found' an aspect of her personal self 'helping people' developed further through 'doing voluntary work', that led to the progression to social work. Stella's talk places a contrast between enjoying 'helping people' which led her to social work, and the 'financial side' of banking which was not liked and which she left. In Stella's construct, finance is not a part of constituting a social worker self, it is something you leave to do social work. However, current LA's adult social care discourses of professional social work are constructed through the concept of social care as care management, and constituted through performative acts of financial assessments, purchasing packages of care and managing care costs (DoH, 2014b). From a perspective of recruitment and retention, it is interesting to consider that if an attraction to train as a social worker is the construction of the self professionally through discourses of social work as a profession that helps people, how does the LA's construct of social care impact on constituting a professional self? Stella's talk suggests that her construction of social work is one constituted through people and not one with a financial side, this links to the issue of social work and care management, I discuss this issue in relation to MHSW in Section 5.6.

John's talk constructs a route to social work similarly accidental to that of Stella's:

> John (MHSW (m) 7yrs.): I kinda bummed around for a while. I went to work in a rehabilitation hospital [--] it was all mental health [--] people had just been moving on from the wards into the community and they couldn't cope. [they were] taking a step back but to have us there to support them and to learn skills to be independent again. [--] I really enjoyed it and found that I didn't mind getting up and going to work every day.

In John's talk to 'know' what social work is and that you want to 'be one' is through an aspect of his personal self discovered through 'doing'; 'there to support them' and finding that 'that I didn't mind getting up and going to work every day'. For a job to hold John it had to motivate him through 'doing something' that

helped others who 'couldn't cope'*;* being a social worker was that profession. For Sarah, her 'doing' was framed by another as potential for 'becoming' a social worker:

> Sarah (SW (f) 24yrs.): errm, I lurched into it. [--] I worked in the community and it was my then manager who said "have you thought about becoming or working in social work?" [---] it planted a seed and I spent a lot of time talking to this particular manager.

If social work can only be known by doing, it may take someone else to construct what you are doing as 'social work'. In Sarah's talk it was her manager that had recognised from Sarah's work in the community, 'seeing Sarah as a social worker'. Once Sarah had this way of seeing what she was doing through conversations with her manager she took steps herself to become a 'professional social worker'. This theme of the not knowing self and the 'seeing' other was also present in Julie's talk:

> Julie (MHSW (f) – yrs.): I'm a newly qualified social worker and I guess looking back, [--] I got there but didn't really know how I got there. But, looking back I think I skirted around it [---] I worked as a carer [--] I applied for an admin job with the LA adult social care [--] I was a secretary for a service manager [--] when a post came up for a support worker she said to me "have you thought of it? [--] Would you go for it?" and encouraged me. And that's how I kinda got into it.

Julie 'got there' but 'didn't really know how I got there' and took the step after a prompt from her manager who encourage Julie to 'go for it'. I saw in the talk of the social workers that they constituted professional social work as naturally unknown, ill-defined and interwoven with their personal selves. This raised the question if national policy and professional discourses call to change these elements to increase professionalism and protect the profession from crisis, how would these social workers construct their professional selves without them and would what they did still be social work?

This construction of the professional social worker self places it outside of traditional constructs of profession and Flexner's[2] criteria that 'unmistakable professions' possess practice 'capable of communication through an orderly and highly specialised educational discipline' (Flexner, 1915, p.155). For social workers, their construction of a professional self is not contradicted by its 'unknowing and unknowable qualities', it is a 'profession'.

5.3 The construct of an unambiguous social worker 'identity'

The social workers' talk enabled a 'truth' that professional 'identity' as a social worker could be both outside of traditional frames of professional constructs, unable to describe social work or what you did as a social worker and construct a professional social worker self that was unequivocal. Mary's talk makes it possible to do this without having 'the words':

[2] The underline is my emphasis.

> Mary (MHSW (f) 5 yrs.): I already had that [social worker] sense of identity, without calling it social work, I already felt like a social worker. It was already what I wanted to do. I already wanted to focus on social justice, just didn't have the words or the career in mind.

Mary states that she felt like a social worker without the words, and it could be argued that knowing the words is necessary for constructing what social work was, and to 'bring it into being'. This constitutes social work as something you can be before 'having the word's*, being* a social worker is constituted as a constant construct of the personal self and the subject positions and subjectivities prior to the words 'social worker'; 'I already had that sense of identity'. I considered within the patterns of Marys discourse it would not be rational for me to argue that social workers have a weak sense of professional identity (Geng *et al.*, 2011), when Mary constructs this as a constant over time and coherent constitution of her personal and professional self.

Mark's talk in the next extract reflects similar statements found in other social workers' interview talk. This was often drawn from discourses of professional training, social work values and the interweaving with personal discourses of the self. Mark does not reflect the sense of 'crisis' of social worker 'professional identity' produced through the discourses of complexity, uncertainty and problematised social work practice drawn from the literature (see Section 3.7). Mark's talk in reply to the question where do you get your professional social work identity from? does not reproduce a 'real' suggested by the literature cited in Section 3.7, such as Baxter's (2011).

> Mark (MHSW (m) 11 yrs.): I get it [what social work is] from the values that I developed and established in my training, I don't get it from being employed by the LA. I don't get it from following a set of procedures that are defined by an agency, it comes from the values that I hold and I have still got those to hand and I read them every now and [then] [--] I was a health service administrator, manager, and I left that to train as a social worker because I wasn't finding job satisfaction in that and I was wanting to find expression for something, whether it was compassion or not, wanting to support and enable people. And I found a way to articulate that through these [the values] and I still stand by this

Mark's professional social worker subjectivity is actively positioned in constituting what social work is and where he got his knowledge of what social work is; 'I get it [what social work is] from the values that I developed and established in my training'. Mark challenges assumptions that it could be imposed externally from legitimised institutional systems priorities, 'I don't get it from being employed by the LA, [I] don't get it from following a set of procedures defined by an agency'. These professional values that constitute what he does as 'social work' and himself as a 'professional social worker' cannot be shaken or replaced by externally enforced definitions or frameworks. Mark positions the construction of his professional self as separate to these, he is free from being told what social work is as he constitutes his professional self through weaving together a personal discourse (a part of himself that was present but unfulfilled before he entered professional social work training), and the discourse of values-based social work drawn from his training. Mark interlaces elements constituting a personal self, 'wanting to support and enable people' with

discovering the constituent of what social work is, 'the values'. So, although boundaried by the values of social work practice the personal self has enabled an 'expression for something'; the value base of social work enabled the articulation of the self in professional practice.

This is consistent with logics of the talk from social workers relating to how they came to social work and became a social worker. The social workers are not constructing the 'professional social worker self' as problematic, it is problematic however when placed within traditional frames defining what a profession is, and constructed as problematic within the discourses of the literature.

5.4 Discourses of change as constructing 'being a social worker'

Another element that constituted crisis in national discourses of social work was that of social work as subject of frequent change. Within the talk of the social workers it was possible to recognise a discourse of social work as a profession that frequently changed, but rather than constituting a reified professional truth it was woven into normalising discourses or discourses of resistance. In the next extract, Stuart's talk is about the shifting nature of social work. He states that his practice when he first qualified would be unrecognisable and unfathomable now when seen in the context of professional social workers' meanings of today; 'what were you doing?'. This was standard practice at the time Stuart qualified, this was what *you did* as a social worker. What was acceptable as social work practice is not recognisable now as social work. This radical change in practice is normalised through change as a constituting factor of social work as a profession.

> Stuart (SW (m) 26 yrs.): So, when I first qualified I was a community social worker [--] I was the social worker for [--] four thousand people. So, it was generic and I worked [--] with them all. [--] You walked you didn't drive anywhere 'cos it [work] was so near and that used to take me hours. Cos, you would meet everybody on the street and you would have endless conversations with people about what you were going to do. [--] The social work team, we created our own five a side football team and we used to play the unemployed people and everything. And that level of community integration was phenomenal. [--] but when you tell people [now] that idea of being a community [social worker], when you tell people they just look at you 'what [were] you doing?' And I think there [it] is. So, ok, so I think [social work as a profession] is evolving and it's changing. So, it's not a static profession, it's not 'this is what it does', it is determined a lot by the statutory framework it operates in [at] any particular moment in time.

Stuart's construction of being a social worker in the past is produced not only as significantly changed but 'unthinkable' now as social work. The sense of change produced through Stuart's talk reflects several ways of *possible then*, not *possible now*; ways of behaving of doing social work in the community with 'thousands of people', the work was 'societal', 'collective' not 'individualistic', problems and solutions were communal. There was time, and 'endless conversations with people', the place, environment, things Stuart did and who he did it with and how you related to *people* constructed being a 'social worker'. What was constituted as 'the values of social work' has all changed, as now this would not be a possible construct within norms of 'good social work practice' of today's political and legal frames and meanings.

This degree of shift in what social work is and what social workers do professionally by statutory change, is not unthinkable to Stuart, that it is so different as to be unrecognisable, it is not attributed with negating social work as a profession. Stuart concludes, 'So it's not a static profession, it's not "this is what it does", it is determined a lot by the statutory framework it operates in [at] any particular moment in time.' This challenges traditional notions of 'profession'; the focus is on 'what it does' in constituting a professional self, rather than a possession of discrete 'knowledge'. Also change is not a result of new empirical evidence and 'continually refreshes itself through the raw materials of science' (Flexner, 1915, p.154), but as a result of political and legal changes that force modifications to how it practices. In Stuart's talk these changes in social work as profession is coherent because it is 'determined' by a constituting factor (statutory frameworks) that is not stable over time.

Stuart's talk shifts social workers working with 'community' and 'people' to something that is unthinkable now. This is linked to discourses of generic social worker and moves to specialist social worker constructs, such as mental health social worker (see Section 5.6). This shift from generic social work and the government's agenda are combined in Fiona's talk of change in the profession in the next extract. Fiona's talk constructs social work as changed from the past in that social workers are defined more by the age of who they work with, child or adult. She constructs earlier 'specialisation' and more 'specialised' social workers as reconstructing what use to be social work as the domain of' unqualified social workers':

> Fiona (SW (f) 20 yrs.): yes I do [think it has changed] [--] you're more clearly defined as a children's social worker or an adult social worker [--] although the qualification is technically more generic for social workers there is obviously a push for earlier specialisation [--]. I think it <u>will</u> affect the role I'm not sure it has yet because there's not enough people who've come through (training and qualifying) with that mindset. There's still enough [--] social workers who have a broader mindset around. [--] I think the government wants to reduce the social worker role in terms of fewer social workers with only complex cases. I suspect in the not too distant future we will have the reintroduction of unqualified social workers whatever they're called.

In Fiona's use of the term 'obviously' in relation to the push for earlier specialism there is a suggestion that this is no hidden knowledge but a natural and known change. Also, the change although natural is taken beyond one that is constituted through evolution, it is one that is 'pushed'. In the next extract from Fiona's talk it appears that who is doing the pushing is the *government*; this places social work and social workers in a position as subjects which are moved to achieve the government's ideas for what social work will be in the future. However, this does not link to a discourse of social work as a profession in crisis, but suggests that change and change by government as a taken for granted part of social work. Here, in Fiona's talk this change by government is more linked to the nature of social work and the politics of the current government. It is because social work is constituted by the 'doing of social work things', that government's redefinitions of what social workers should be doing produces the reconstruction of what social work is and who are social workers.

> Fiona (SW (f) 20 yrs.): the current government does not like social workers and does not like the people they work with. [--] (social workers) will say, you know, life circumstances have meant that this person has arrived here and we should now be doing our best to empower them to move on. Not blaming them but enabling them. Because social work will continually [--] advocate for, you know, the whole of the code of conduct is about, enabling and not labelling [--] which the current government is so fond of doing.

Fiona's talk places the social workers' fundamental values-base, the unique core of the profession's identity (Roche, 2004), in opposition to the government's agenda and priorities. In Fiona's discourse, it is not that social work is ill defined producing change, it is its contentious relationship with the government, the 'government does not like social workers and does not like the people they work with'.

If a truth is established through the literature of a necessary link between limited or no statutory change to enable professional social work not to be in crisis, social work is likely to be constructed as a profession in perpetual crisis. The talk of the social workers suggested that change was a natural constituting factor of professional social work and a dynamic related to the *doing* and *being* of social work. Social work was not changed because there was a problem with what it was of itself but because what it was and what it did conflicted with the government's political position. Therefore, for social work not 'to be changed' it would need to be doing what the government of the time *liked* and to be working with the *people they liked.* In contrast to the literature, the problems that 'social work has' as constructed in the talk of social workers relates to the reconstruction of social work, not by the profession altering through new professional knowledges, but by shifting towards traditional notions of 'profession', and moving to constructs underpinned by technical knowledges of individualist specialisation. Social work's reconstruction by government political agendas and statutory frameworks shift generic 'social work' into 'unqualified' nameless subject positions.

The implication of this analysis suggests that MHSWs will have reduced subject positions based on concepts of professional social work as done in the community and through talking to people. They will be drawn from discourses of professionalism which construct social worker selves through 'technical specialist knowledges' and individualist positioning with people with mental health problems (in contrast to community and collectivist solutions), in attempts to separate and distinguish a professional self from constructs of generic social work constituted as 'unqualified' social work practice.

5.5 Media discourses of a 'failing' profession

The talk of social workers drew from discourses of social work as a profession that has failed (also see Section 3.8). These discourses constituted social workers as professionals who had failed society, families and in their duties at a fundament level, neglecting its core values to protect the vulnerable and to demonstrate commitment to social justice. Rose (1999) argues the forming of existences within the mass media plays an increasing part in the shaping and regulation of the self and subjectivities. In another extract from Stuart

below it is possible to see how media constructs of social workers are as professionally failing, and the subject of severe public criticism, comes into being as part of who Stuart is as a social worker. Applying Foucault's notion of technologies and techniques of the self, understanding how a person acts on themselves to place themselves as the 'subject' of discourses and applying Althusser's (2001) concept of interpellation and discourses as 'hailing', the media discourses hail Stuart into being 'that social worker', failing and criticised. Stuart reforms and shapes the *skills*, *feelings* and *confidence* of being a social worker and in his professional practice. Stuart shares how his professional self is reconstituted through these discourses, 'you know that clearly has an impact about how you feel about yourself, and how you feel about your job'.

> Stuart (SW (m) 26 yrs.): You know, the deaths of Victoria Climbié and Baby P, [--] are real knocks to your own confidence and your own skills and erm. I think being a social worker is much maligned and, you know, very heavily criticized and you know that clearly has an impact about how you feel about yourself, and how you feel about your job.

It is interesting how when Stuart uses the phrase 'I think being a social worker is much maligned', that he uses 'being a social worker' rather than 'I think social work is much maligned'. This brings the 'much maligned' into his subjectivity of 'being a social worker' from the external discourse of social work as the object of discourses. In Stuart's extract, it is powerful how tragic and painful real events such as the death and injury of a child come to define not only the profession of social work but also bring their own notions and meanings of being a social worker and the personal self (Stack, 2010).

In Section 3.8, Galilee had raised issues of media impact on social work and the need to be more 'media savvy'. This was not reflected in the talk of the social workers, but being 'politically savvy' was, as in the next extract from Fiona. She links 'image' and attractiveness of the profession with discourses of political ideologies, also as mentioned in Section 3.8. This discourse can be seen in Fiona's talk in the extract below where she places a direct relationship between this and public opinion; 'they've made it (social work) not publicly acceptable'. This extract follows on from Fiona's earlier extract in Section 5.4 where she stated, 'the current government does not like social workers and does not like the people they work with'.

> Fiona (SW (f) 20 yrs.): I think they have done their best to diminish the role of social work [--] make what we do less, I mean [--] they've made it not publicly acceptable. You know, the whole idea of 'well if a social worker allows a child to die we'll stick them in prison for 5 years', is hardly enabling, is it?

The sense of a politically motivated governmentality of social workers is drawn into the construction of being a social worker. Also, political use of the media to influence a shift in meanings of social work and social workers from friend of the community and advocate to a *diminished* position, linking with the discourses of public mistrust, and as raised in Stuart's talk earlier, of social work as maligned and heavily criticised.

In Jack's talk below, social work is also troubled by government but through a different challenge:

> Jack (SW (m) 34 yrs.): So, it's very important in my image as a social worker to try and look straight on with no prejudices and judgements as far as I'm able [--] to step back [--] through the use of sociological, psychological theory [--] to formulate an intervention. Quite a thought through process with people. [---] I think in many places the social worker identities have been degraded and I think many others share this view. [--] the Community Care Act 1990 introduced the notion of assessment and care planning, introduced the notion of, I think LA's introduced the notion of bureaucratisation of social work or the administration of social work. So, that rather than going through that more interpretive process I've described, with the help of a computer [--] you could [--] quickly [--] go down a pick list of interventions for this person. [--] (using a manual) you could tell people what to do at each stage and therefore wouldn't need as many qualified social workers [--] non-qualified (social workers) could operate a care management process and that's pretty much what happened.

This talk is not only of a diminishing of social work, but a 'degrading' of social work. Jack's extract constructs the challenge to social workers as 'degrading' their role through the 'bureaucratisation' of social work and 'administration' of social work. This would introduce the logic and meaning that social work was not a professionally skilled job, 'therefore wouldn't need as many qualified social workers'; these are constructed as replaceable with 'non-qualified' workers. This shift in meanings directly impacted on Jack's social worker subjectivities. In the previous extract, he compares the constituting of social worker subjectivity through a notion of a skilled professional, with government and LA notions of social work and the role of 'doing' social work, brought into being by the Conservative Government and legitimised through the Community Care Act of 1990 (1990a).

The discourse of government *degrading* social work also surfaced in Galilee's review of the media representation of social work and the influence of politically aligned media reporting. Galilee (2005) cites Franklin & Parton's (2001) position that 'the attack on social work' fitted with the 'Thatcherite' goal of 'degrading local authorities' which were seen to be pursuing a 'loony left' agenda. This linked to free market principles of the government, by legitimising the provision of social care through non-statutory organisations and developing a market economy of non-statutory services.

In an earlier extract, Mark's talk surfaced the discourse of expression of personal fulfilment through finding social work as an occupation to demonstrate how his personal and the professional subjectivities are intertwined. In the following extract from Jack's talk, the struggle of interwoven personal selves and professional selves is seen through inter-subjectivities within public spaces and outside the discourses of work. Jack produces a social worker subjectivity which is drawn from the values of professional social work; 'BASW's values statements or the international definition of social work', and weaves this directly to the personal, it is taken into the self, it is 'internalised'.

> Jack (SW (m) 34 yrs.): BASW's values statement about social work or the international definition of social work. If you read that and what that talks about [--] it does become internalised. So, whether I'm here (place of work) at home or in the pub [--] [I] still have that sense. Sometimes I wish I didn't have it because it's quite constraining [--] I think it's an identity that you carry everywhere. I try so hard to be non-judgemental about the situations and ethical about the

> situations [--] you can't kinda take that off. [--] I'm quite shocked by a lot of pub talk (hearing highly prejudiced conversations).

Jack's talk suggests that not only the personal self shapes social worker subjectivities but that social worker subjectivies come into the construction of the personal self and relationships to others in the 'non-work' environment. The rules and logics that constitute the professional self in the discourses and social practices present in every day work and are also brought into the worlds and technologies of the personal self. Jack finds that this is so woven into the self, he can't 'take that off'; his comment 'sometimes I wish I didn't have it' suggests commitment to his social worker subjectivity *constrains* possible personal subjectivities in his life, and there is no 'outside of' the rules and logics of social work practice. Therefore, bringing together Stuart's comment on the impact of media discourses and Jack's explanation of how this impacts on his personal selves, it is reasonable to argue that national media discourses of social work as failing and the subject of public criticism would have impact on the social workers' constructions of their personal selves. As Jack states, their social worker subjectivity is placed 'everywhere'. Adding to the unambiguous construct of 'social worker' discussed here, this constructs the social worker as a sustained 'self' in all contexts.

If it is not the construct of 'social worker' that is produced as challenging in their talk, as this is unambiguous and sustained, then it is reasonable to suggest that the challenge of constructing 'MHSW' is linked to producing the specialist MHSW subject, and a professional social worker self within the discourses and social practices of NHS mental health settings. The following sections explore the construction of the MHSW subject, and how this is subjectively produced within the discourses of the NHS mental health settings and the subject positions possible. In Chapter 6, the implications of this analysis are considered within the context of the policy visions, both past and current, of MHSWs working in integrated health and social care NHS-MHS.

5.6 Generic social work, 'past' 'awful', does not construct 'professional'

As Section 3.11 noted, under the NHS and Community Care Act 1990 (1990b) LA's responsibility moved to providing adult social care through care management. The implication of this was seen by many to de-professionalise social work, as care management introduced the post of care manager. This could be, but did not have to be, fulfilled by a qualified social worker. The process of care management, assessment and purchasing and reviewing care packages for people meeting the criteria for social care, was perceived by many social workers as mechanistic and adhering more to principles of managerialism than professionalism (Sheppard, 1995). LAs moved away from employing adult social workers to work directly with communities, usually as generic social workers where social work is seen as having common basis in which its values, knowledge and skills can be applied to a range of situations (Trevithick, 2012, p.141), to ones with a more removed and centralised role as brokers and micro-commissioners of care (Sheppard, 1995).

In Sections 3.9 to 3.12, the development of MHSW as a specialism of social work (in contrast to generic social work or positions as care mangers), is placed within policies and shifts in what constituted good and modern NHS-MHS, as formed through multi-disciplinary health and social care teams (DoH, 1999). This offered disconnection with generic social work and care management, to take up a social worker position, still employed by the LA to deliver social care, as a professional within NHS multidisciplinary mental health teams. This was an opportunity to develop as specialist (Trevithick, 2012); a professional self constructed as having superior knowledge and skills about people with mental health problems and the NHS mental health setting.

Stuart, whose earlier extract in Section 5.2 talked of the social work of the past, returns to the notion of generic social worker in the following extract. Stuart constructs being a generic social worker as in the past 'I think back when' and as: 'awful, terrible, embarrassingly poor', and 'unsophisticated' by comparison to social work practice today. Stuart places himself alongside the specialist social worker perspective through shifting from the meaning of generic social work from brilliant to awful, and the awful viewed through discourses of regret, concern and inappropriateness when working with people with acute mental health difficulties:

> Stuart (SW (m) 26 yrs.): Yes, well I think back to when I was a generic social worker, you know, on one level it was brilliant, on another level it was awful, you know. The quality of the assessments I used to write, terrible really. Um, you know, really embarrassingly poor actually. I think, that being my only exposure to people with mental health difficulties, you know, I think back and I think, God, some of the things I did. But I mean it was all sort of well-intentioned but there was that bumbling along and shed loads of common sense but actually not very sophisticated really, you know, [for working with] people with quite acute mental health difficulties.

In comparison to Stuart, Barbara is a MHSW working in a NHS-MHS, she constructs the nature of 'past generic social worker' in relation to a now 'better MHSW' differently. Barbara constitutes generic social work and community social work as a lost but appropriate way of working with people with mental health difficulties. Also as a solution to delivering care more holistically in contrast to specialist social work that is constituted as fragmenting the worked with person:

> Barbara (MHSW (f) – yrs.): I was born into a generic [--] workforce, and there [--] was a certain, er, appropriateness and, er, respectfulness to generic work which I think we've lost in specialisation. Um, because you know we [social workers] are holistic and that's our big thing you know. Somebody could be schizophrenic with a broken leg and three kids they can't look after them, where do you go? You know what I mean? [--] of course, before there wasn't that problem [of working beyond the treatment of the disorder]. So, we [social workers] were much more able to be responsive to the whole situation. Whereas now, erm, I'm still responsive to the whole situation but I'm supposed to be a mental health worker, so it kind of puts this weird kind of constraint on it really, which I don't really like.

Barbara's account places generic social work outside of current discourses constituting acceptable social work practice. It demonstrates a shift from constituting the work with a person with mental health difficulties from a person having physical needs 'a broken leg' and a parental role, having 'three kids', all

relevant to what generic social workers did, to a necessary position of priority for the mental health disorder *schizophrenia*, necessary to constitute the specialism of mental health social work.

Barbara's comment 'that's our big thing, you know' when referring to social workers practice being holistic, brings to the surface through the 'you know' the suggestion I might not know, that it may have been 'lost in specialisation'. That is, for Barbara, she has not only lost that way of working but what was also lost was knowing it as a 'big thing' that constituted social workers as '*being'* holistic care through their place in communities and generic responsibilities. For Barbara to take up the subjectivity of generic social worker she has to draw from discourses of this as a lost, but respectful and appropriate, subject position. This is in contrast to Stuart's previous account where generic and community social work is constituted as awful, terrible, embarrassing, learnt through exposure, well intentioned and based on common sense.

Barbara's use of the phrases of 'born into' a generic workforce suggests this is her natural and real social worker subjectivity, and 'supposed to be a mental health worker' suggests an externally applied expectation of Barbara as a social worker, now working with people who have mental health difficulties. This introduces the notion of two subjectivities forced together. The initially created subjectivity of generic social worker is constrained to enable the space for the mental health worker subjectivity drawn from specialist mental health discourses. A constraint that is 'weird' when meanings of MHSW are *not* draw from discourses which Barbara uses to constitute her professional self as a real social worker.

These extracts from social worker Stuart and MHSW Barbara bring to the surface several tensions, contradictions and choices within professional social work subjectivities. Traditionally a profession is separated from nonprofessional work through a hierarchy of classifications of knowledge that privileges scientific above non-scientific, education between routine schooling and university doctorate, and elite and non-elite occupations (Evetts, 2014). Specialisms give access to discourses that would adhere more closely to recognisable criteria of a professional based on these traditional notions so can be viewed as sophisticated and more equipped to match the constituted complexity of the acute mental illness that is worked with. This brings in a tension as the specialist knowledges are drawn from bio-medical and psychological discourses that are contradictory to discourses of professional social work constituted through values rather than facts, and people rather than patients.

5.7 MHSW constructed as <u>not</u> generic social work

Using the approach to analysis set out in Chapter 4, frequent patterns associated with bio-medical discourses could be seen in the talk of the MHSWs interviewed. For example, within bio-medical discourses I saw the right to speak as located in the subject who had the most legitimised medical knowledge, the doctor. This brought into being 'the patient' through the doctor being the professional who could see illness and classify it within categories of severity and morbidity. Other knowledges and subject positions were subjugated and

supplemental to these constructs. The rules of this discourse placed priority and ethical imperative (doing the right thing at the right time, in the right order and way), on the actions that only the doctor can do, delegate or monitor (diagnose, treat, prescribe for or discharge from care). Performative acts that are legitimised by specialist 'scientific' knowledges and qualifications constitute the authority to make clinical decisions and judgements. In the following extracts from Mary the range and the tensions between MHSW subjectivities can be seen as she makes it clear, 'That wouldn't feel like I was doing my social work job', reflecting the importance of her position as a NHS mental health care co-ordinator to do social work. The care coordinator position is a professionally neutral subjectivity, in that a nurse could equally hold this role, but makes available a subjectivity of a specialist rather than generic social worker.

> Kim (researcher): Your training was generic; do you think there is anything specific about social work in mental health?
>
> Mary (MHSW (f) 5 yrs.): Yeah, traditionally since the NHS and Community Care Act a lot of those adult roles have been focused on care management, and I guess hasn't been. Care co-ordination, which is slightly different so we haven't just been putting in care packages and reviewing. We've been working alongside people. [--], for example, there is no way I would go for a job in another adult [social care] service as it stands. Because I don't feel like that would be satisfactory as a social work role.
>
> Kim: Because?
>
> Mary: Because, [--] I couldn't just have that small contact [with service users] around care package management, I just couldn't. That wouldn't feel like I was doing my social work job, yeah.

So, Mary's rule is, to do 'social work' in adult social care she has to work in a NHS-MHS which offers a different role, that of 'care co-ordination' resisting what Jack raised in the extract earlier the 'degrading' work of 'care package management' which is a function for social workers who work as care managers within LA adult social care. Following the construct formed from 'not generic' I asked Mary how she would describe herself as a social worker in mental health:

> Mary (MHSW (f) 5 yrs.): I guess in the team here erm its obviously very medically focused, it's the medical model. Erm and so quite often in the team discussions will be around medication, [--] I find that often I will be the person that recognises issues around human rights, capacity issues people. Erm having a choice about what they want to happen to them [--] it's not to say that other professions don't think that but I think that first then other things come, like medication and other things. Whereas maybe some of the doctors particularly or nurses will think what are the symptoms what are the treatments [--] so we'll come at it from opposite ends.

Mary's answer surfaced the naturalness of the team that they work in to focus on the medical; 'the team here is obviously very medically focused'. Mary can be seen to have set out several permitted, although varied in satisfaction with them, MHSW subjectivities and subject positions. It is not an adult social care subjectivity, as it is not one as case manager because that is incompatible with social work, and therefore not being a social worker. But Mary's social worker subjectivity *is* constituted through the NHS mental health

setting. This is achieved through bringing a social worker subjectivity constituted through discourses of human rights and choice into the spaces left and produced by bio-medical discourses.

Working within the NHS-MHS both enabled distance from generic social work and LAs, and enabled positions as a NHS member of staff. In Joan's extract below this is constructed initially as choice which is made through conscious decision:

> Kim (researcher): When you are working with members of the public and when you're working with a client, how do you feel that social worker identity exists in that process? [--] how do they define you as a social worker?
>
> Joan (MHSW (f) 9 yrs.): I think I pick and choose how I portray myself, I think that's quite a conscious decision. Erm because obviously, there are different identities that I could pick from, I could say that I'm a social worker, erm I could say that I'm a NHS member of staff you know I walk round with an NHS lanyard erm I suppose those are the two main ones. [--] I don't think it's probably as conscious, I just try and use whichever identity I think will be most useful in building a relationship with that person depending what the aim is of my visit or telephone call is.

Joan has permission, 'I could say I'm an NHS member of staff', however this is qualified with the evidence that, 'I walk round with an NHS lanyard'. I would argue that a NHS lanyard could be seen as a visually discursive call to a NHS subject position, and part of the dominant discourses operating in the social practices of the institution. Wearing a NHS lanyard would be a signifier which would require additional acts to reconstruct the self as a social worker. It is interesting that Joan later states 'I don't think it's probably that conscious', suggesting a naturalised NHS construct of a professional self that Joan operates rather than Joan selecting where and when to wear the NHS signifier.

Sometimes the subject positions made possible within discourses and the social practices of the institutions are irreconcilable, within the constructs of professional social worker. In this extract from Mary the team offers a position constructed bio-medically, constituted through administering medication by injection, a *depot,* and observing *mental state* to monitor illness status.

> Kim (researcher): Where do you feel your social worker identity is the weakest?
>
> Mary (MHSW (f) 5 yrs.): I suppose um when we're in team meetings, maybe when we're talking about maybe assessing people. [--] When you're allocated some work it's not necessarily allocated in terms of professions. So, somebody [service user] comes into the team, and they need to take a depot [injection]and some follow up [ongoing monitoring] around mental state. Initially the discussions will be around who's best to do that. But of course, that's not how it works because of [low staff] numbers. So, that might come to me as a social worker and I feel completely deskilled at that. [--] because I can go and quite happily talk to about how things are but I have absolutely no skill in delivering a depot [--] that's the furthest away from something I can do but also, [--] when I was at university I was learning to do all the other things we talked about and more. [--] It was much more about family orientated work, work in the community, making use of resources. All the things that actually transforming lives is about, fantastic for me but not so fantastic I guess when your trapped in that kind of medical process.

Mary draws from bio-medical discourses through the mention of 'mental state' and 'depot'; both are tasks more associated with nurses as a depot is an injection and nurse qualification gives nurses the authority to administer prescribed medication. Managerial discourses are also drawn from through the reference to 'because of numbers'; the pressure to get this done will be driven by the team manager and is linked to notions of 'targets' and 'team performance'. Mary constructs what she should be doing as a social worker in NHS-MHS from discourses drawn from her professional training and qualification seen in the reference to 'when I was at university'.

This final extract from Mary is where she responded to my question, 'Where do you experience your identity as a social worker the strongest?' She draws from several discourses – bio-medical, social justice and human rights, generic specialist – but the space and construct of the role of an AMHP enables her to interweave these to produce a less conflicted subjectivity; quite the opposite it is a more intense production of the ideal professional social worker self.

> Kim (researcher): When, where do you most strongly experience your sense of identity of being a social worker?
>
> Mary (MHSW (f) 5 yrs.): I've just trained as an AMHP, so definitely as an AMHP. When you're in that situation where doctors are there saying, we want somebody to be detained, instantly you're thinking of all the other options and least restrictive practices, you're trying to work with the family as well as well as the service user. [--] I'd say that's when I think, yeah this is where I'm a social worker without question in this role. Whereas in the team [--], it's a bit more generic role in comparison. We have to address so many different things, [--] as a care coordinator you're not there just to do care packages or to look for community resources you're also there to discuss medication and those kind of things. So, it's more widely spread. Whereas in the AMHP role it feels quite concentrated social work role.

In these extracts, Mary moves through various subjectivities, and subject positions. She often frames these positions by comparisons with others that are possible for her a social worker self, such as generic social worker, but are less favourable. To construct a professional MHSW self, Mary needs to be in the NHS mental health team. This enables the production of a specialist mental health subjectivity but it is constructed from a professionally neutral and again genericist role within the team, the role of care co-ordinator. However, this is necessary to access the subject position as an AMHP as sponsorship by LAs for the formal AMHP training often follows from experience of working in NHS-MHS (Morriss, 2014). The AMHP position can be constituted from the core constructs of being a professional social worker and can be interwoven with a specialist mental health social worker self. In this subject position, it is possible for Mary to construct a professional self within the social practices and institutional regimes of truths operating within the NHS-MHS.

Mary resisted one degrading construction of professional social work as care manager, through the construction of her professional self as care co-ordinator in the NHS-MHS, one which made her social worker self invisible. In taking up the AMHP subject positon Mary could resolve both generic and degrading

subjectivities, resolving conflicting subjectivies, and take up a subject position that was coherent within the social practices of the institution and the performative acts and constructs of professional social work.

5.8 Typology of subject positions

Drawing from Parker (1992) and Foucauldian principles (O'Farrell, 2005) I looked for the different discourses within the text, studied the impact of discursive elements and looked for the subject positions within these for the subject positions and what social worker subjectivities were produced (Parker, 1994, p.95). The analysis of the social workers' texts resulted in recognition of 6 social worker subject positions within NHS mental health settings. These became visible to me through an iterative process of drawing together repeated patterns of meanings, logics and rules from discourse analysis of the social workers' talk, the literature, and my subjectivities as insider and outsider through a reflexive process and subjectivity analysis.

In Section 2.4 I explained how, in this research, discourses are seen as constructing the nature of the subject. The subject (a type of person) has specific rights and ways to speak in the text and is positioned in the discourse according to rules for the possible relationships between subjects of that discourse. Each discourse also sets up rules about who can occupy what subject position. In Section 2.6, I discussed how subjectivities are understood as where the person transforms the self into the subject of a particular discourse, through a process of subjectification. See Section 4.11 for examples and how I analysed the social workers' talk in relation to subject, subjectivities and subject positions.

The subject positions below relate to the research question of how MHSWs construct their professional selves, in that they suggest what subject positions are offered within the discourses available within NHS-MHSs. These subject positions may be moved between moment by moment as the MHSW draws on different discourses that are available to them to construct their professional self.

The six subject positions I saw in the talk that were possible for MHSWs were:

1) **Care coordinator** – linked to language, processes and rules of Care Programme Approach, being a multidisciplinary team member, risk assessment, expert knowledge of the NHS systems. This is a position close to bio-medical and psychological experts. This subject position was not exclusive to social workers and could be taken up by nurses or occupational therapists. This was a specialist subject position for social workers within the context of LA adult social care giving access to power/knowledge positions and professional expert discourses with the NHS mental health system, but was a generic position within NHS-MHS.

2) **Service user champion and advocate** within the NHS mental health system – linked to language, processes and rules of recovery, navigating the system, service user choice and control and positions close to service user. This subject position was not exclusive to social workers and could

be taken up by nurses, psychologists, doctors, service users, formal advocates or occupational therapists. This discourse links to constructs of social worker through discourses of social justice and definitions of what is unique to social work.

3) **Therapist**- linked to history of social work and past social worker subjectivies of counsellor and counselling skills, linked to language, processes and rules of psychological, psychodynamic interventions, CBT (Cognitive Behavioural Therapy), family work, therapeutic models, counselling, holistic and strengths approach and expert knowledge. This subject position was not unique to social workers and could be taken up by psychologists, nurses, doctors, independently trained therapists and volunteers within charitable organisations. It is legitimised through the frameworks of roles and skills of social work, and links into discourses of interventions, evidence based practice and specialist skills.

4) **Deliverer and knower of LA (Council) duties**, systems and processes - linked to language, processes and rules of the Care Act 2014 (2014), care-management, voluntary and community services, personal budgets, support packages and direct payments. This was not a unique subject position to social workers and can be held by care managers, officers of the council, and staff from independent organisations. In the discourses and subjectivities this was aligned with administrative, bureaucratic subjectivities, removing social workers from specialist and service user champion subjectivities and aligning them with mechanistic unskilled processes.

5) **Professional social worker** -active promoter, protector and embodiment of social work values and ethics - linked to language, processes and rules of qualifying, training, values base, supervision, BASW, constituting the professional as campaigner and activist. The only subject position unique to the social worker and unique to the social worker in the mental health multi-disciplinary environment. Offers a position of existence through resistance.

The AMHP subject position below, as mentioned in Section 3.12, was only available to take as a MHSW if further formal and statutory training was successfully completed, and a LA approved the social worker once they have completed the training. The process of becoming an AMHP and working as one, is regulated under the Mental Health Act 1983 as amended in 2007 Sections 114 -115 (2007). See Appendix 9 for AMHP approval regulations.

6) **Approved Mental Health Professional** – linked to languages of mental health law, human rights, resistance to medical oppression, mental health specialist and advocate. This subject position was not exclusive to social workers and could be held by other professionals, link to notions of elite

autonomous and in demand professional, danger, complexity and high risk, and notions of real social work and 'doing' real social work (Morriss, 2014; Morriss, 2015).

The analysis of the social workers' talk interviewed for this research provides an understanding of the discourses that MHSWs drew from in constructing their professional selves in the context of NHS-MHS. The discourses that were drawn from highlighted the subject positions available when the participating social workers constituted their professional self as a MHSW. Barbara's account, for example (Section 5.6), reflects the impact of weaving discourses of generic and holistic social work with that of herself and MHSW position within the NHS-MHS discourse. Extracts from Mary's talk, the weaving of different discourses, (Section 5.7), specialist social worker (not generic adult social worker or case manager), care coordinator and AMHP, are all used to construct her professional social worker self. Joan's account (Section 5.7) reflects how this moving through subject positions can be done consciously and out of awareness. These subject positions are not what social work *is* or what MHSWs' professional identity *is*. The subject positions reflect the discourses that were available to the MHSWs to draw from to construct the professional selves, within the discursive effects and social practices of the institution of the NHS-MHS. I argue that if discourses changed, broadened or were differently ordered MHSWs would have the opportunity of different subject positions, subjectivities and constructions of the self as professional.

The typology of subject positions provides a useful way of thinking about and reflecting on MHSW practice, and prompts for MHSWs to consider their subjectivities within the context of constructing their professional selves, particularly within the discourses and discursive practices of the NHS-MHS. The typology of subject positions can provide an accessible, and researched, resource for critical reflective social work practice in mental health social work. A practice resource that is underpinned by an in-depth critique and contribution to social work's body of researched professional knowledge. Chapter 6 discusses the implications and application of the analysis presented in this thesis in the context of continuing drives towards health and social care integration and suggests potential applications of this research for MHSW practice.

Chapter 6 Discussion and conclusion

6.1 Placing the discussion in context

There are several wider issues relevant to contextualising the critique I have argued in this thesis (Shaw, 2010) and these are discussed in this chapter. I have presented in this study new understandings of how MHSWs construct their professional selves within NHS-MHS produced from interviews with 12 social workers practicing in England, responding at particular instances of time, place and meaning. At the time of completing the research the majority of LA MHSWs worked within integrated NHS-MHS, and integration continued to be the national policy direction for health and social care services (LGA *et al.,* 2016). However, over recent years some LAs have withdrawn their MHSWs from integrated services and have provided mental health social care through aligned (with NHS-MHS) social work teams (Allen, 2014). This study has not included MHSWs working in this context. Additionally, since commencing this research a new programme of social work professional training has come into place. The Think Ahead[3] programme fast tracks university graduates to qualify as social workers with an expertise in mental health social work where all placements are within mental health services. The first cohort is still in training at the time of writing and due to conclude in Autumn 2017. It would be useful if future research recruited participants from the two MHSW groups; those working in aligned teams, and those qualifying through the Think Ahead programme, to add additional understandings of MHSWs' constructions of professional selves. I also acknowledge there may be areas where social care and health have worked well in integrated multi-disciplinary NHS-MHS. The UK Government's national project, Social Work for Better Mental Health, launched in 2016 (Allen *et al.*, 2016) is intended to highlight successful practice by social workers in mental health services. At the time of completing this study the project was still to report on its early findings.

This research has not explored the institutional context and the social practices of the institution within its operative environment, and the physical environment's discourses' interpellation of subject positions and subjectivity. As Section 4.9 explored, I observed the environment where the social workers were based whilst completing the interviews and was aware that this would be a rich area to explore for future research into MHSW practice, both in NHS-MHS and non-NHS mental health services such as voluntary organisations.

In this research, I have focused on adult MHSWs and I have not claimed any production of knowledge in relation to the construction of other social worker professional selves. For example, older peoples' social workers, social workers in NHS children and adolescent mental health services, and social workers working in

[3] Think Ahead programme is a new route into social work for graduates https://thinkahead.org/about-the-programme/

child protection. Whilst some of the findings arising from this research may be useful in thinking about these specialist areas of social work, this was outside the remit of the current study. It may, however, be useful to explore the benefits of applying the approach I have taken in this study to researching the construction of professional social worker selves in these other areas of social work.

6.2 Methodological challenges and contributions

As raised in Chapter 3 there was scarce research literature in relation to studying how MHSWs construct their professional selves within the problematic context of NHS-MHS. Existing research did not overtly take a discursive approach and mainly provided accounts of the problems of MHSW in NHS-MHS, such as stress and burn out (Huxley *et al*., 2005), MHSWs as marginalised within NHS-MHS and in crisis (Nathan & Weber, 2010), and MHSWs work as invisible within NHS-MHS (Morriss, 2016).

Therefore, through taking a discursive approach to studying the concept of MHSWs' professional selves in NHS-MHS, this research has brought new knowledge and 'ways of seeing' to the critique and debate of MHSW practice within NHS-MHSs' integrated multi-disciplinary teams. By using the concepts such as discourses, subject positions and the social practices of the institution, I was able to analyse the talk of social workers and access subtle, nuanced and multi-faceted understandings of the issues, not confined to linear and singular explanations. One challenge of this approach was the time the analysis took to complete and the considerable amount of material it produced. Also, in balancing my excitement of accessing a rich way of understanding the research question, I considered accessibility of the knowledge produced. I found an important aspect of the approach was finding ways to present the information to people, unfamiliar with Foucauldian concepts, that did not exclude them from critiquing the application of my research to everyday worlds of MHSW practice (Tew *et al.,* 2006).

Another methodological issue I encountered was whether as a non-social worker I could or should complete research into professional mental health social work, (see Section 4.14). The relationship between frontline social workers and research informed practice has been ambivalent, from the perspective of social work as uniquely values-based, and linked to resistance to traditional professional constructs (see Section 3.6). The need for social work research was often located within calls for social workers to embrace research as part of developing and securing social work as a profession (Webber, 2013; Manthrope & Moriarty, 2016). Of the MHSW studies I reviewed the majority were completed by social workers (for example Nathan & Webber, 2010; Bailey & Liyanage, 2012; Wiles, 2013; Morriss, 2016). However, there are benefits to being an 'outsider' (Corbin-Dwyer & Buckle, 2009) as this can add alternative ways of seeing (Parker, 1992). I received considerable encouragement from MHSW peers who reassured me it was benefitial that a mental health professional, who was not a social worker but had experience and knowledge of NHS-MHS team working, was exploring this topic with the potential to bring outsider insights. In this research, the combination of my professional interviewing experience as a CPN within a CMHT, and the social worker's professional expertise,

experience and familiarity with the use of interviews (see Section 4.7) generated a rich resource of social workers' talk for analysis.

6.3 A reflexive analysis of my researcher journey and position within the research

During my work on this project I have viewed my reflexive activity as a self-conscious and deliberately assumed subjective position that is part of the research process (Parker, 2005), and have completed several notebooks of my thoughts and reasoning during my work as researcher. I have extracted matters from these notes that have had a particular bearing on my position within the research, and the context of producing the meanings, conclusions and claims to new knowledge that I have presented in this thesis. These extracts also include where the research process impacted on me, as this seemed inseparable (Wilkinson, 1988). I acknowledge that I have been a part of the discursive practices and discourses I have been analysing, and that present in all the stages and my moments of decision making will have been my culturally and historically produced subjectivities, and constructions of my personal and professional selves (Foucault, 1984: Foucault, 1988).

6.3.1 Discovering subjectivities and my researcher assumptions.

At the time when I selected the research focus and developed the research question (see Chapter 1, Section 1.5), I was not aware of the degree to which my role as a LA manager had influenced my decision and where subjectively I was positioned within the discourses of mental health social work. This struck me during one of the early research interviews with a MHSW. It was the first time I had met him, he had volunteered to be interviewed after he had heard of my research from a colleague that he worked with; he and I had no previous or other relationship. He was very interested in the subject of social worker identity within NHS-MHS and had been keen to participate. I was listening to him explaining that his identity was drawn from his personal experiences and social work values. In these moments, I was aware of how I had become immersed and constructed through my LA's culture, where all meanings were framed within the context of implementing the Care Act 2014, a high-profile priority and pressure on all of the LA's systems and policies. I had realised my difficulty to bring together the LA's and NHS-MHS partnership agreement (see Section 1.4) had be the catalyst for the research question; I had not realised how much of my LA manager self had influenced what I thought I was going to hear. I had expected MHSWs to automatically draw from LA culture and that this would appear in their talk.

As a result of this insight, I acknowledged my assumptions of how MHSW's would construct their professional selves. I checked the interview schedule for any reflection of this assumption that might affect the MHSWs' answers or steer them into discourses that they would not have otherwise drawn from (Taylor, 2001). I did not change the interview questions as these did not emphasise a LA role in the production of MHSW selves (see Appendix 5). This was also reflected in the social workers' responses which contained very little reference to LAs in relation to constructing a professional self. When I analysed the research material

once I had completed all of the interviews, the very little connection I found between the discourses drawn on in the talk of the MHSWs when constructing their professional selves and the LA's was a surprise. It challenged the assumptions I had held when developing the research question and the recruitment pack (see Appendix 4), prior to completing the interviews.

My reflexive notes show that this was a time when I became most aware of my position as a Doctor of Professional Practice (D.Prof.Prac.) researcher rather than a Doctor of Philosophy (Ph.D) student. I had been excited by the opportunity that a D.Prof.Prac. provided me to complete an in-depth inquiry into my real-world problem as social care manager/practitioner-researcher (Taylor & Hicks, 2009). However, it was also a challenge because as a D.Prof.Prac. researcher I was far closer to the problem that I was researching. I was immersed in my LA role, culture and frames of meanings far more often than I was in my researcher position or university environment. This experience, and the reflexive thoughts following the event, resulted in a considerable shift in my assumptions within the research process, particularly regarding my understanding of the relationship between the MHSWs' professional selves and the culture of LA's in the context of Care Act 2014 duties. I was surprised by the degree that I had been socialised into the LA's culture, which had become naturalised within my own, what I thought was, open minded thinking. As a result of this insight, I had a new way of seeing MHSWs (as professionals with autonomy to define themselves through their professional, knowledge, skills and training rather than constructed through the priorities of the LA); one that was more of a challenge for me as a LA manager, however, was more useful to me as a researcher.

6.3.2 Completing the interviews and subject positionings.

As a novice discourse analysis researcher, I had spent considerable time thinking through the ethical issues of being in the researcher position (Hammersley, 2014). I was being trusted with the social workers' information, beliefs and views on what was a very personal and, for many, passionate part of their lives. I knew that the research interview was an occasion where power differences could affect the research process (Taylor, 2001) and one which was 'fraught with tricky issues' (Burman, 1994, p. 49). I was uncomfortable with how familiar the interview situation felt for me, and how easily I moved into interviewing people. It took considerable persistence throughout the interview process to make the experience fresh and strange, and to resist slipping into the familiar subject position of colleague with a project to complete. I have held several roles within mental health and social care; practitioner, manager and commissioner, where there has been a workforce or redesign project where I am gathering information as openly and inclusively as possible. I had also completed research before using different methodologies and methods, including focus groups, questionnaires and mixed methods, always within the context of NHS-MHS multidisciplinary settings and focused on improving mental health care (for example Fulford and Woodbridge, 2007, p152).

My concern was I needed to bring into my 'seeing' the power, gender, age and cultural issues that were present within the interview process, and challenge myself to make explicit how I addressed these beyond

what had become naturalised in my social practices and familiar subject positions. I found the most effective way to do this was to consider the interview as an event where both I and the social worker were positioned, and where we were positioning ourselves through subjectivities and discourses. I considered the subject position I occupied and those that I was offering. Through this process, I became sensitive to the CPN subject position (for example see Section 1.3) and MHSW power assumptions within NHS-MHS institutional hierarchies, and ensured that I emphasised my position as researcher. The interview process did not conform to the usual colleague to colleague discussion format with ideas shared, challenged or agreed, and was focused on the understandings offered by the social workers interviewed.

I had to acknowledge myself as culturally positioned subject within the norms of societal hierarchies; this is not something I have often considered reflexively during my other roles. I am female, white British and middle class from a working-class back ground. These factors resonated with many of the social workers participating. The majority were female, all were white and many mentioned a working-class background prior to their social work careers. It is probable that my head nodded at comments that resonated with my own experiences and that I would not have 'heard' talk that was outside my resource of discourses, meanings and constructions. These issues did not dissipate once the interviews were completed, and I became more fully aware of them when analysing and writing up my analysis of the social workers' talk.

6.3.3 Analysing the material and writing up.

I found the process of analysing and writing up the social workers' talk the most challenging activity in the research process, and it was where I noticed most personal change in relation to becoming a researcher. I found myself in an unproductive loop of not being able to take myself out of the research, not completely knowing all the ways I had impacted on the research (as I had only my part of the social constructed event), and with a sense that whatever I did must be ethical and fair. I wanted to go back to the research interviews and ask questions of the social workers about power issues such as gender, profession and class directly. I realised that I was still holding positivist assumptions of 'clean and objective' production of new knowledge, and needed to move to recognising that, as Burman states, 'Put simply, there is no way of avoiding adopting some kind of position' (Burman, 2003, p.3). Continually attending to a reflexive researcher position I was more able to 'see' discourses, subject positions and acknowledge my own. It was also possible to move from viewing subjectivity and positioning of myself as researcher from a concern to be managed, to a resource that could be harnessed through the scrutiny and challenge of the reflexive process (Burman, 1994). For example, my concern that I was not a social worker enabled me the opportunity to consider my positions as both insider and outsider researcher (see Section 4.14). I also reminded myself that I was analysing discourses, not people, and I was not analysing or making claims in relation to the intentions, meanings and beliefs of the social workers or looking to make a true statement of the professional MHSW in a NHS-MHS

(Taylor, 2001). I was sharing my analysis of the discourses I saw in the social workers' talk, and the meanings that I made through that process in writing this thesis.

My journey through this research process has caused me to challenge my own assumptions about MHSW's and what I was expecting to find when I investigated the research question. Being aware of my assumptions and subject positions through continuous reflexivity was important when I analysed the social workers' talk. I became very aware that my position as a researcher was indistinct, and that it was confused within my subjectivities and constructions of my professional self drawn from other discourses and subject positions (practitioner, manager and commissioner). I spent time reading the social workers' talk with these questions in mind - what could have been influencing this choice of question and answer? What were the assumptions I was making? What was the social worker assuming in their response? What could be acting as barrier or facilitator to their response – my profession, age, gender, background? I found this focused my attention on the complexity of the interview situation and the potential power imbalances that could influence what a social worker said, what I heard and the meanings I made from what I was reading.

I found completing the analysis one of the most challenging elements of the research and it revealed the importance of reflexive time to consider issues such as gender and power; not only 'seeing and hearing' them in the research interviews and materials but also in my own work and personal experiences. If I complete a similar study in the future I would consider including questions that would directly cover issues such as power, gender and professional hierarchies as these are such relevant factors not only to the focus of the research, but also to completing the research. I have acknowledged that the researcher is always present in the research process at each stage, but believe through the continual challenge of the reflexive process that the arguments made are substantially formed and shaped by the talk of the social workers interviewed for this thesis. Further comment on the context of the arguments, analysis and conclusions drawn in this thesis are discussed in Section 4.13, 4.14 and 6.7.

6.4 Professional selves – alternatively constructed to policy discourses

An important part of this thesis was to understand the complexity of practicing as a MHSW set out in Sections 1.1 and 1.4, how MHSWs constructed a professional self. This developed into the research question:

> What discourses do MHSWs draw from to construct their professional selves in the context of (adult) NHS-MHS, and what were the implications for that professional self of the subjectivities and subject positions possible within these discourses? (see Chapter 1, Section 1.5).

Responses from the social workers interviewed reflected a professional social worker self constructed from personal discourses, as seen in Mark's extract in Section 5.3, where he wanted to 'find expression for something' which he found through social work. This was closely linked with the values- based discourses of social work found in Mark's earlier talk in the same extract when emphasising where he gets his social worker identity from:' I don't get it from being employed by the LA. I don't get it from following a set of

procedures that are defined by an agency, it comes from the values that I hold'. This was also seen in Mary's extract (Section 5.3), where she felt like a social worker before she had the words for social work. Mary also reflected the discourse of social work as indefinable and knowable as she says '"err" is a noise I'm familiar with', when asking people what they think social workers do (Section 5.2).

Discourses of social work as unknown and unarticulated were also reflected in the social workers' accounts of their routes into the profession, not through a planned and visioned self, but through accident and prompts from others. For example, Sarah 'lurched into it' (Section 5.2) with encouragement from her manager. Social work was also naturalised as always changing as seen in Stuart's extract, 'So, it's not a static profession, it's not 'this is what it does'' (Section 5.2). Professional selves constructed from these discourses, contrast significantly to traditional notions of a profession (Flexner, 1915; Abbott & Meerabeau, 1998), and the communication of professional knowledge, 'unmistakable professions are capable of communication through an orderly and specialised educational discipline' (Flexner, 1915, p.155), discussed in Section 3.3. This resonated with discourses constructing social work as in crisis and as a problematised profession in the literature (Asquith *et al.*, 2005; Moriarty *et al.*, 2015). In contrast, the social workers interviewed drew from these discourses (of social work as indefinable, unknown and uncommunicable, personal and frequently changeable), to construct the professional self as a social worker and doing social work. A construction, permitted and made logical through its interweaving with discourses of the uniqueness of social work as a profession that it is constituted through its professional values (Chechak, 2015) rather than claims to scientific knowledges. This discursive reasoning was reflected in Mark's and Jack's constructions of their professional self, see extracts in Sections 5.3 and 5.5 respectively.

National policy discourses call for frontline social workers to develop practice research and evidence, and to share how they use research (Romeo, 2016). These discourses also argue that greater articulation of definitions and clarity of social work are essential for the profession's future safety (Moriarty *et al.,* 2015). Such discourses produce a professional social worker subject position that assumes a professional self constituted through social work as measurable, knowable and communicable. I suggest it would be useful for professional social workers and social work training programmes to consider how the discourses and discursive meanings, used by practicing social workers to produce their professional social worker selves, suggested in this research, can be brought together with what appear to be, at their core, differently constituted professional social worker subjects found in national discourses?

6.5 Generic and specialist discourses – caught between a rock and a hard place

Within the discourses of the social workers interviewed, generic social work was linked to the past and a form of social work not sufficiently sophisticated for working with people who have mental health problems; see Stuart's extract in Section 5.6. In addition, as mentioned in Section 3.11, LA adult social care provision became defined as care management (NHS & Community Care Act 1990, Section 47. 1990b; DoH, 2014b). In

Mary's talk (see Section 5.7), the resistance to a professional self constructed as a LA care-manager subject could be seen in, 'there is no way' she could construct herself as a social worker working in non-mental health adult social care services: 'that wouldn't feel like I was doing my social work job' (Section 5.7). Therefore, it is possible to reason that for some social workers, working in a NHS-MHS enables them to construct their professional selves as social workers, whereas working in LA's adult social care service does not.

However, within the NHS-MHS discourses, Barbara's and Mary's constructs of a professional social worker self suggest subject positions with NHS-MHSs are suppressed and limited by bio-medical discourses of mental health operating discursively within the social practices of their environment. This contrasts to the social worker subject constructed through policy discourses, which contributes unique social knowledges and skills, perspectives, models, interventions, through practice alongside those of health colleagues (Romeo, 2016). Mary's talk (Section 5.7) produced a team that was 'obviously very medically focused' and a professional self that was 'completely deskilled'. Mary had a potential professional self that's was 'fantastic' but one that was 'trapped' in the 'medical process'. Within the discourses that Mary draws from it is difficult to see where MHSWs working environments, either LA or NHS-MHS, have subjectivies and subject positions available to construct a professional social worker self as envisioned; in professional training programmes, as Mary's talk constructed: 'when I was at university I was learning to do all the other things we talked about and more' (Section 5.7), or the mental health social worker practice constructed in national policy rhetoric.

6.6 The five role categories of MHSW and the typology of subject positions

Prior to considering the application of the research to practice I considered the typology of subject position from Section 5.8 with current guidance for MHSW practice in mental health services. In 2014 Allen produced *The Role of the Social worker in Adult Mental Health Services* (Allen, 2014), (see Sections 3.7 and 3.9). This was guidance for MHSW on their role in mental health services. It had government and professional support with a forward by the Chief Social Worker for Adults, Lyn Romeo, and the then Minister of State for Care and Support, Norman Lamb. The guidance presented 5 role categories for MHSWs working in adult mental health (Allen, 2014, p.6); these are listed below. When I considered these categories in the context of the typology of subject positions drawn from discourses of the MHSWs I interviewed about their professional identity within NHS-MHS, I made observations which I have added below each of the role categories.

- **Role Category A.** Enabling citizens to access statutory social care and social work services and advice to which they are entitled, discharging the legal duties and promoting the personalised social care ethos of the local authority

Observation: this links to subject position 4: **Deliverer and knower of LA (Council) duties**, systems and processes. I saw this as a subject position which was resisted and seen by MHSWs as de-professionalising for social workers. It was rarely drawn on in the discourses and from this I would suggest fulfilling this role category maybe problematic within the social practices of NHS-MHS.

- **Role Category B**. Promoting recovery and social inclusion with individuals and families

Observation: subject position 2: **Service user champion and advocate** within the NHS mental health system can be seen as link to this category. In my research MHSW's constructed this as a position of challenge and resistance to the bio-medical discourses of mental health and NHS systems (for example Mary's extract Section 5.7).

- **Role Category C.** Intervening and showing professional leadership and skills in situations characterised by high levels of social, family and interpersonal complexity risk and ambiguity.

Observation: Using the regulations for being and AMHP I could link this role category with subject position 6: **Approved Mental Health Professional** but was not often drawn on by the MHSW in constructing their professional selves.

- **Role Category D.** Working with local communities to support community capacity, personal and family resilience, early intervention and active citizenship.

Observation: I could link this category with some of the discourse I saw within the interviews that I completed with the social workers; it was usually relating to the generic social worker, a role for social workers in the past. I did not see a subject position produced within MHSW discourses that I would link with this category.

- **Role Category E.** Leading the Approved Mental Health Professional Workforce

Observation: my research was focused on MHSW so did not explore the AMHP position but this does link to subject position 6: **Approved Mental Health Professional** which was constructed a position where it was possible to construct a professional social worker self within the NHS-MHS.

This thesis provides a rich researched resource available for social work practice. It strengthens a critical social work approach (Healey, 2005; Heron, 2005; Fook, 2012) by giving detailed examples of how the application of Foucauldian theory and concepts, (discourses, subject positions, subjectivities and the challenging of 'taken for granted ways of seeing'), can provide a flexible toolbox for self-reflection in any practice context (Foucault, 1974). The typology of subject positions makes a key contribution to professional MHSW practice in a way that has previously received little research attention (see Section 3.1).

6.7 The limits and implications of the new knowledge created

The essence of discourse analysis within this thesis has been the search for patterns in the social workers' talk that reflect 'a system of statements which constructs an object' (Parker, 1992, p5), that I have seen through my understanding and application of a Foucauldian approach and Parker's steps to achieving discourse analysis. I acknowledge that I have been positioned and have positioned others within this research programme of work (see Section 6.3). In addition, the talk that I analysed was from 12 people, all of whom like myself, were positioned and situated within a cultural and historical produced system of assumptions, meanings and truths. If I had interviewed different social workers from different NHS-MHSs and from different parts of the United Kingdom, I may have had different talk to analyse. If I had been a social worker I may have seen and heard different patterns and drawn different meanings into the analysis of the social workers' talk. Throughout the research process I have engaged actively and reflexively with the question, interviews, transcription, analysis and reporting, and in Sections 4.13, 4.14 and 6.3 I have shared my position within the research process. The conclusions I have drawn and the implications and recommendations I have presented in this chapter, should not only be placed within the arguments I set out in Chapter 2 Theoretical approach to understanding and analysis, Chapter 3's Review of the Literature and particularly in Chapter 5 Analysis, but also within the context of my subject position and subjectivities as a manager/practitioner-researcher.

As mentioned in Chapter 1, I have assumed that the concept of mental health social worker is socially constructed. In line with that premise and adherence to a robust methodological approach the following paragraphs consider the implications of the new knowledge produced. I stated in Section 5.8 that this research does not claim to know what the MHSW's professional identity *is* or what it should be in NHS-MHS. In this thesis, I have argued for and presented a typology of subject positions drawn from the discourses available to MHSWs when constructing their professional selves, within the discursive effects and social practices of the institution of the NHS-MHS. Within the context of integrated multi-disciplinary working this has implications for the practice of MHSWs. The following is a summary of the main implications following on from my research arguments and conclusions:

1. The conclusions drawn from the analysis suggest that the culture and environment in which the MHSWs work has a significant impact on their construction of their professional social work selves. This supports recommendations made by Godden *et al* (2010) and Allen (2014) regarding what NHS-MHS need to do to support MHSW (see Appendix 3).
2. Due to the high demand on NHS services and the acuity of the mental health needs of people who meet the criteria to be admitted to NHS-MHS, social workers are hailed into medically constructed mental health worker positions. The social perspectives, interventions and models of mental health are overshadowed by the dominant medical imperatives within the NHS-MHS

institutional practices. Mary's talk (Section 5.7) showed that this was due in some regards to high numbers of people needing support and low numbers of people in the team to meet that need.

3. The shift from generic community social work, which included working holistically with people who had mental health problems within their home environment, to specialist MHSW positions within NHS-MHS's disorder specific treatment pathways (such as for schizophrenia), has impacted on the degree to which MHSWs can work holistically, as seen in Barbara's talk (Section 5.6). I was aware in my own experience that MHSW's often wanted to work beyond the organisational limits of the NHS-MHS. For example, to use their specialist social work skills to work with people who had a complex and severe mental health problem in their home environment to increase their independence and social inclusion, but could not as the person's mental health needs did not meet the threshold of acuity necessary to be accepted for admission or for treatment by the NHS-MHS.
4. By applying the notion that subject positions, discourses and discursive frames affect what I could see or hear as a researcher in the talk of MHSWs, to the context in which social workers practice, I considered, based on the arguments set out in Section 5.3 and 6.4, whether the difficulty of seeing social work in NHS-MHSs was less about the MHSWs ability to articulate their professional selves, and more because a social way of seeing mental health is not a frequently used way of seeing, within the context of NHS-MHS, or by other professional disciplines or within the general understandings of mental health within society (ComRes, 2017; Carter 2017). Therefore, those managing or working alongside MHSWs as colleagues would need to develop ways of seeing social understandings of mental health, social interventions and social work within the NHS-MHS context. This would also have the benefit of increasing the social understanding of mental health by people using NHS-MHS services and their relatives.

6.8 Recommendations for social work theory and practice

Learning from the research completed, its implications and returning to the research question and its practical origins, I recommend the following to enable mental health social work to be visible at all levels within integrated services, to assist professional colleagues and managers to see social work and social workers within the NHS-MHS service, and to build a working relationship between LAs, NHS-MHSs and MHSWs.

1) Building on the work completed by Godden (2010) and Allen (2014), that any NHS-MHS that is providing an integrated health and social care service in partnership with the LA places social care, social interventions and social models of mental health on an equal footing within its governance (such as clinical governance) structures and processes. That the standards that are set and agreed within the governance framework are not defined or overshadowed by the

responsibilities of the AMHP role. There is a clear understanding of what constitutes social care, social work and social interventions, informed by social models, social perspectives, social theories and evidence.

2) That within NHS-MHS that are committed to delivering health and social care services all operational infrastructures acknowledge and make visible social understandings of mental health, social care and social work. For example, in software systems used for routine recording work with people with mental health problems, all operational policies, performance frameworks and quality improvements systems.

3) That as routine within integrated services, all standards of practice, job descriptions, appraisal and supervision practices, explicitly include what constitutes social care, social work and social interventions.

4) That professional leads, frontline mental health social workers, AMHPs and programmes such as Think Ahead, develop theories of professional mental health social work and social worker. This should form a critiqued construct of a mental health professional social worker self, not overshadowed conceptually by the AMHP role. This is to add to social worker constructs and to consider what specifically constitutes the 'mental health social worker' professional practice.

5) To do this in multiple imagined settings and not limited by NHS-MHS discourses and constructs, and to critique this within multi-disciplinary perspectives and team practices.

6) LAs and professional MHSWs should collaborate to develop understandings of what adult social care means for people with mental health problems, drawing both from the LA's duties under the Care Act 2014 (2014), and particularly the underpinning principle of wellbeing, alongside MHSW constructs of mental health social work practice.

7) Drawing from sharing understanding, theories and models of mental health social work, to publish a practice resource written for MHSWs, LA and NHS managers, people using services, voluntary organisations and the public, that links LA duties under the Care Act 2014 (2014) within NHS-MHS and professional mental health social work practice. The publication would use language that was accessible, and would be salient to the systems, meanings and practices of LA's, professional mental health social workers and NHS-MHS, with scenarios and responses to people's frequently asked questions (for example from the public, people using services, relatives and staff).

I have made these recommendations with the intention that these will develop the social discourses, constructs and subject positions that mental health social workers can draw on, within their practice working with people with mental health problems, that resonate with their professional social worker selves. Also, that they will provide a shared resource for partnership working and the integration of health and social care within NHS-MHS. Because of the importance of the public understanding of mental health social work (see Section 5.5) my intention is that these resources are also developed to inform the public, people using services or their relatives, what social care services are and how they can be accessed. That this is not only informed by LA and NHS-MHS statutory information but also discourses of social understandings of mental health and mental health social worker practice.

6.9 Further applications for practice – training resource pack

Following completion of this study my intention is to use the findings of this research to produce a professional development resource pack for mental health social workers working in NHS-MHS services. The pack could be used by students and social workers for self-directed study, supervision and reflection, or by trainers to run workshop sessions. The resource pack will raise useful questions for critical reflexive social work practice and group debates within programmes of study, such as,

- What do I draw on to sustain my sense of professional self, how do I communicate and constitute professional knowledge?
- In considering the subject positions suggested in this research, how do they resonate with my sense of professional mental health social worker practice?
- What is the place of MHSWs in NHS-MHS and LA adult care services, and how does this relate to the work fulfilled by social workers who are AMHPs?
- How does my job description and day to day practice as a MHSW relate to a sense of being a professional social worker, the 5 role categories (Allen, 2014), delivering social care and the Care Act 2014 with its underpinning principle of wellbeing?

The targeted organisations and initiatives for discussing the development of this resource pack include; Skills for Care[4], British Association for Social Work (BASW), Association of Directors of Adult Social Services (ADASS), Mental Health Network, Social Work for Mental Health project and the Think Ahead Programme.

National policy continues to drive forward with integration of health and social care as a solution for the problems facing both services at this time (LGA *et al.*, 2016). In this context MHSWs' practice has much to offer people with mental health problems. Recent findings from a survey of the public still found that the role of social workers in mental health services are significantly misunderstood (ComRes., 2017; Carter,

[4] Skills for Care provide practical tools for adult social care http://www.skillsforcare.org.uk/Home.aspx

2017). Previous research has shown that MHSWs' practice becomes invisible within NHS-MHS, and that they have difficulty articulating a professional social worker self in this context (Morriss, 2016). This thesis assumes that social workers will be better equipped to articulate their professional selves within the complexities, conflicts and professional power imbalances of NHS-MHS if they are supported with the tools to respond proactively to these issues. The findings from this study will provide a rich resource for social workers to engage with, to support them in making their (alternatively constructed and unique) professional practice visible and available to people with mental health problems using NHS mental health services.

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Appendix 1 Definitions of Social Work

Social work definition

Social work in its various forms addresses the multiple, complex transactions between people and their environments. Its mission is to enable all people to develop their full potential, enrich their lives, and prevent dysfunction. Professional social work is focused on problem solving and change. As such, social workers are change agents in society and in the lives of the individuals, families and communities they serve. Social work is an interrelated system of values, theory and practice.

Theory

Social work bases its methodology on a systematic body of evidence informed knowledge derived from research and practice evaluation, including local and indigenous knowledge specific to its context. It recognises the complexity of interactions between human beings and their environment, and the capacity of people both to be affected by and to alter the multiple influences upon them including biopsychosocial factors. The social work profession draws on theories of human development and behaviour and social systems to analyse complex situations and to facilitate individual, organisational, social and cultural changes.

Practice

Social work practice addresses the barriers, inequities and injustices that exist in society. It responds to crises and emergencies as well as to everyday personal and social problems. Social work utilises a variety of skills, techniques, and activities consistent with its holistic focus on persons and their environments. Social work interventions range from primarily person-focused psychosocial processes to involvement in social policy, planning and development. These include counselling, clinical social work, group work, social pedagogical work, and family treatment and therapy as well as efforts to help people obtain services and resources in the community. Interventions also include agency administration, community organisation and engaging in social and political action to impact social policy and economic development. The holistic focus of social work is universal, but the priorities of social work practice will vary from country to country and from time to time depending on cultural, historical, legal and socio-economic conditions.

It is understood that social work in the 21st century is dynamic and evolving, and therefore no definition should be regarded as exhaustive.

(BASW, 2012, Code of Ethics for Social Work pp.6-7)

International definition of social work

The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.

(BASW, (2012) Code of Ethics for Social Work, p.6)

Social Workers commitment to three basic values:

1. Human rights – respect for the inherent worth and dignity of all people as expressed in the United Nations' Universal Declaration of Human Rights
2. Social justice – a responsibility to promote social justice, in relation to society generally, and in relation to the people with whom they work
3. Professional integrity – a responsibility to respect and uphold the values and principles of the profession and act in a reliable, honest and trustworthy manner

(BASW (2012) Code of Ethics for Social Work, p.8)

Appendix 2 The Task Force's 15 recommendations for comprehensive reform

- **Calibre of entrants**: that criteria governing the calibre of entrants to social work education and training be strengthened.
- **Curriculum and delivery**: an overhaul of the content and delivery of social work degree courses.
- **Practice placements**: that new arrangements be put in place to provide sufficient high quality practice placements, which are properly supervised and assessed, for all social work students.
- **Assessed Year in Employment**: the creation of an assessed and supported year in employment as the final stage in becoming a social worker.
- **Regulation of social work education**: more transparent and effective regulation of social work education to give greater assurance of consistency and quality.
- **Standard for Employers:** the development of a clear national standard for the support social workers should expect from their employers in order to do their jobs effectively.
- **Supervision**: the new standard for employers should be supported by clear national requirements for the supervision of social workers.
- **Front line management:** the creation of dedicated programmes of training and support for front line social work managers.
- **Continuing Professional Development:** the creation of a more coherent and effective national framework for the continuing professional development of social workers, along with mechanisms to encourage a shift in culture which raises expectations of an entitlement to ongoing learning and development.
- **National Career Structure**: the creation of a single, nationally recognised career structure for social work.
- **National College of Social Work**: the creation of an independent national college of social work, developed and led by social workers.
- **Public Understanding**: a new programme of action on public understanding of social work.
- **Licence to Practise:** the development of a licence to practise system for social workers.
- **Social Worker Supply:** a new system for forecasting levels of supply and demand for social workers.
- **National Reform Programme:** the creation of a single national reform programme for social work.

(DoH, 2010, p.25)

Appendix 3 BASW Policy recommendations

12.1 Principles to support social workers working in CMHTs and community mental

health services

It is recommended that the following measures are adopted. The measures all refer to principles

and ethics that are captured in the BASW code of ethics (BASW, 2012):

- The BASW Code of Ethics is adopted by Health Trusts and Social Service Partners to underpin the relationships within and between the partners
- Health managers must recognise that social work is a profession with its own principles and codes of conduct and unique knowledge and skill set. This knowledge and skill set includes safeguarding, the mental health act, case management and personalisation, but also relates to wider knowledge emanating from research and practice. This includes a high level of understanding of the social model of disability.

12.2 Practices and processes adopted in order to achieve the principles

It is recommended that the following practices and processes are adopted in order to ensure

that social workers are well supported in community mental health services and that social work

continues to make a significant and positive contribution to mental health services:

- That Health Trusts and Social Service Partnerships sign up to the BASW 5-star engagement plan endorsing their commitment to social work
- That the implications of the introduction of PbR are seriously considered by Health Trusts and Social Service Departments in order to avoid the disintegration of multi-disciplinary teams
- An interagency group is established specifically to oversee Section 75 agreements
- Regular governance meetings at senior management level to monitor partnership arrangements are instituted
- There needs to be social work representation at Trust Board level. A member who clearly owns the local authority social care portfolio
- Social care is recognised as an integral part of a Trust's mission statement
- When the commissioning of mental health services is moved to GP commissioning practices that recognition of the vital role of social care and social work is recognised by commissioners
- There needs to be strong on-going local authority engagement at senior management level with mental health services in order to ensure that the social care model, personalisation and the social work role are effectively embedded in Health Trusts
- Social care models are incorporated into the training of all mental health professionals
- Clear lines of accountability, leadership and support is given to middle managers in taking the social care agenda forward
- The value of the social care workforce is promoted

- Anyone responsible for personnel issues – recruitment, disciplinary, grievance and absence are trained in the requirements of the local authority, Care Quality Commission, Social Work Codes of Practice, Social Work Task Force recommendations
- Social care leaders should ensure that that support services are in place for social workers – IT HR, finance, learning and development. This includes ensuring that social workers, whether seconded to Trusts, or directly employed have the tools to engage (such as access to local authority internet and intranet and recording systems) with social service departments
- Social workers and social work managers should be engaged from the outset in the development of plans to re configure and change services
- Robust arrangements are put in place to ensure that social workers receive good quality supervision from qualified social workers:
    - Professional supervision within the team from an experienced social Worker
    - Support for the experienced social worker from an external mentor
- There should be an adequate number of social workers in CMHTs
- There should be a social work forum in each locality, that is separate from other professions in order to build and sustain identity
- The issue of unequal terms and conditions of employment between professions needs to be addressed
- Detailed governance arrangements are instituted so that arrangements are not reliant on personalities, or the enthusiasm of particular managers
- Clarity is developed regarding which personnel policies are followed – Trust or Local Authority
- Support for social workers is given to take on leadership roles in mental health trusts
- Support is given to social workers to strengthen capabilities and social workers' ability to do their job well.
- Managers in mental health services need to recognise the importance of team working and the value that different professional roles bring to the teams
- Where necessary appropriate development work, involving all members of multi-disciplinary teams, takes place to ensure that there is mutual understanding of roles. Relevant toolkits should be used to facilitate this
- That the recommendations of the Social Work Task Force for the profession – including supervision, training and development and qualifications are followed and implemented when they become policy.

(BASW. (2012), BASW. Policy on Social Work in Multi-Disciplinary Mental Health Teams)

Appendix 4 Recruitment Pack

Participant information sheet

This information sheet is for participants who may volunteer to participate in the study being completed by Kim Dodd, into social worker identities within mental health practice.

You have received this information sheet and consent form because I (the researcher) would like to approach you to be involved in my research study. Please read this information sheet before deciding whether you would like to volunteer to be involved in this research and before signing a consent form if you wish to be a participant. This information sheet is not intended to replace any discussion you may wish to have with the researcher and I would welcome your questions and comments.

The title of this study is….

"A deconstruction of social worker identities within the context of NHS mental health services".

In this study deconstruction is a form of analysis that assumes that the term, social worker identity, has several meanings, that no one meaning is the right one and that people will have several identities rather than one constant identity.

The purpose of this study is….

….to understand social worker identities in mental health practice. There has been considerable focus on the low morale of social workers and the challenges to social worker identities when working in health settings. Social workers who work within multi-professional and predominantly health models of care may experience their roles as blurred, and merging and changing with others. Therefore, at a time when social work practice is under change to meet national and local social care strategies it is important that we have an opportunity to capture and comprehend how social workers understand their identities, how these identities are socially constructed and sustained within their place of work and what discourses such as policy or professional discourses they may draw from.

The researcher is….

…. Kim Dodd, RMN, RNMH, MSc, PgDip, DMS, PgCert, BSc. Head of Mental Health Cambridgeshire County Council. Contact details: Mobile 07500 228 446 or direct line 01223 729057. E-mail kim.dodd@cambridgeshire.gov.uk

I am completing this study as part of a Doctorate in Professional Practice at the University of Northampton. This study is subject to the standards and regulations as set out for the University and additionally for Cambridgeshire County Council Research and Ethics Board. In completing this study my research practice will be supervised by my supervisory team at the University, if at any time, you have concerns regarding my research conduct please contact Michelle Pyer at michelle.pyer@northampton.ac.uk who is part of my supervisory team. If you have any concerns regarding your experience of participation in the research from an employed Cambridgeshire County Council social worker perspective and would like to discuss these, please contact XXXXX, Head of Professional Practice, Cambridgeshire County Council, at XXXXXX@cambridgeshire.gov.uk.

The study involves….

……interviewing you on the subject of social worker identity, each person who agrees to take part will be interviewed for approximately 45 minutes, it may be a little shorter or longer. This interview would be at place of mutual agreement, it is intended that this would be a comfortable, quiet and

private room where the participant and the researcher would not be interrupted or distracted. If it was agreed that a second interview would be required and the participant was in agreement then a second interview of similar length may take place. During the interview if the participant would like to use images to explain a response to a question, for example a picture depicting social care that represents information the participant wishes to share in relation to social work identities then this would be included in the analysis.

What will happen to me if I take part?

If you agree to take part I will ask you to complete the written consent form and I will ask you for your contact details. I will contact you and we will arrange a convenient time and place and I will then interview you. I will have a list of questions I can ask you but they are a guide and are not fixed. If you would like to bring an image or picture with you that represents social worker identities then we can use this in the interview and I will ask you to describe it and what it means. I will record the interview and then the interview will be transcribed. I will send you a copy of the transcript for your information once transcription has been completed. You may have a friend or colleague present when completing the interview if you wish, this would be at your discretion.

I will be interviewing other participants and the information from your interview and any analysis will be added to other interviews for further analysis.

You may withdraw your consent up to one week from the date of your written consent after this time it will not be possible to with draw from the study.

What will happen to the information?

The information given will be stored in a locked filing cabinet. The identity of each participant (you) will remain anonymous throughout the research process and in the report. I will do this by assigning a number for your views. From then on you will be known only by your number. Once the research is completed, the information will be destroyed two years following the completion of the study. When I write the report of the study, it will not be possible to identify you or anyone else who participated in the study. I will send you a copy of the final report when completed.

The information you give will be for research purposes only. As mentioned there will be a final report additionally I will publish within appropriate journals elements of the research and the findings. However, Individual information will not be given to any other party.

What are the risks?

It is not anticipated that there will be any significant risk related to becoming a participant, however, it is not possible to make this assumption in all cases. Therefore, if you would like to discuss any risks you think there are in participating and we could jointly complete a risk assessment, if you wish to do this please contact me before you make a decision to volunteer or not.

Do I have to take part?

Taking part is **completely voluntary** and you **may withdraw up to one week from the date of your written consent without prejudice** and your involvement or your withdrawal from the research will not impact, negatively or positively, on any relationship we may have outside of this research study. If you have any concerns regarding the research at any time please contact me, details above, and I will reply writing, taking any reasonable steps to reassure you that your concerns have been addressed.

There is no payment for involvement and the researcher is unable to cover any travelling expenses.

If you have any questions or would like to discuss further please do not hesitate to contact me.

Kim

Kim Dodd

Mobile: 07500 228 446 or direct line 01223 729057. E-mail: kim.dodd@cambridgeshire.gov.uk

Consent form.

Title of study.

A deconstruction of social worker identities within the context of NHS mental health services.

Researcher.

Kim Dodd, RMN, RNMH, MSc, PgDip, DMS, PgCert, BSc. Head of Mental Health Cambridgeshire County Council. Contact details: Mobile 07500 228 446 or direct line 01223 729057. E-mail kim.dodd@cambridgeshire.gov.uk

Please complete the following by initialling each box to confirm agreement with the statement

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw up to one week from the date of my written consent, without giving reason. ☐

3. I agree to take part in the above study. ☐

4. I agree to the interview being recorded ☐

6. I agree to the use of anonymised quotes in publications ☐

Name of Participant	Date	Signature
_____	_____	_____

Name of Researcher	Date	Signature
_____	_____	_____

Appendix 5 Interview schedules and prompts

Interview schedule and prompt questions

The researcher will remind the participant the session will be recorded and that it is voluntary. The researcher will give a brief recap on the purpose of the study and the conditions of the interview as set out on the information sheet. The researcher will ask if there are any questions the participant would like to ask before starting. The researcher will then ask a few introductory questions such as…

How did you become a social worker? Do you think social work in mental health has changed? What do you think is the best thing about being a social worker?

The following list of questions is an example of the questions that will be asked. The questions may change during the interview dependent upon the participant's responses to enable flexibility in capturing useful information. Questions may also change as a response to emergent discourses or meanings arising in the interviews[5].

1) How did you come to train as a social worker? What do you find rewarding about social work?
2) What do think is core to social worker education and training? How does this relate to their identity in practice?
3) Please tell me in your own words what is at the core of the identities of social workers?
- Are there any recent conversations or discussion, article or a picture that captures this, that would be a good example?
- How close do you feel to that now?

4) How do you think people get a sense of identities as social workers?
- Where does it come from how do people keep it?
- Where is it most strongly reinforced and how?

5) What do you think 'social worker' means in mental health services now?
- What makes the difference to what it means?
- Where is social work most strongly apparent in services, (meetings, documents, articles, colleagues, pictures)?

6) What does integration mean in practice to social workers?
- Does it impact on identities, where and how?

7) What is the social worker's relationship to Mental Health Payment by Results?
- What makes the relationship like this?
- What would happen/ does happen if social workers are involved in delivering MHPbR?
- Where does your knowledge of Mental Health Payment by Results come from (meetings, documents, articles, colleagues, pictures, personal experience)?

8) What is the social worker's relationship to personalisation within current mental health practice?
- What makes the relationship like this?
- What would happen/ does happen if social workers are not involved in delivering personalisation?
- Where does your knowledge of personalisation come from (meetings, documents, articles, colleagues, pictures, personal experience)?

9) Is there a relationship between your professional identity as a social worker and your personal identity?
10) What is it that makes others aware that you are a social worker?
11) How do people relate to you as a social worker? Is it different when you are at work than when you are not?

[5] Banister, Peter; Burman, Erica; Parker, Ian; Taylor, Maye and Tindall, Carol (1994) *Qualitative Methods in Psychology. A Research Guide.* Open University Press. Buckingham.

Appendix 6 Marks used in transcription and within extracts

A Pseudonym was used to indicate which participant was speaking

My name (Kim) was used to indicate researcher speech

I used an Underline to indicate emphasis

I used … to mark hesitation or a pause

Speech that I removed for confidentiality reasons was noted with square brackets around what had been removed e.g. [name of hospital] or [name of manager].

Reported speech was placed in "quotation" marks

CAPITALS marked shouting or very loud speech

If the participant was laughing or crying this was also added within the sentence in round brackets, e.g. (laughing).

Marks used in extracts

Where a sentence, phrase or word existed in the transcript that has not been included in the extract I have marked this with a dash within square brackets.

For example:

Transcript: I always base my acts on my values. This paper here has them written on. These were the ones, 5 of them, I have them here. They are important to my practice.

Extract: I always base my acts on my values. [--]. They are important to my practice.

Some words were change or omitted for the sentence to read more understandably.

For example:

I worked was yesterday, I changed to, I worked yesterday.

If I added a word for clarity I placed it in square brackets [ ]

For example: yes, I do [think it has changed]

(Modified from Parker, 2005, p.65)

Appendix 7 Parker's steps to discourse analysis

Discourse is realised in text.

Step 1. If not already then convert into a written form

Step 2. Free associate with the text.

A discourse is about objects

Step 3. Systematically itemize objects that appear in the text.

Step 4. The objects are organized and reconstituted in the text through particular ways of speaking. These ways of speaking should be referred to as objects, the objects of study, and the discourses. This brings the researcher to the point of identifying the discourses that hold together the objects referred to in the text.

A discourse contains subjects

Step 5. Systematically itemise the subjects, the categories of people, these may also have previously been identified as objects.

Step 6. Reconstruct the subjects as a method to explore differential rights to speak, what each person is able to say within the framework of rules suggested in the text. Through this it is possible to reconstruct the rights and responsibilities, positions and relationships of the main subjects within the text.

A discourse is a coherent system of meanings

Step 7. Map the different versions of the social world that co-exists in the text, identifying the assumptions and their implications.

Step 8. Speculate on how the collective pattern of meanings, assumptions, rules and responsibilities would respond to objections or challenges to the rules, including any hidden cultural rules. This process assists in the constructing the separate discourses.

A discourse refers to other discourses

Step 9. Identifying contrasts between the ways of speaking.

Step 10. Identify where the ways of speaking overlap.

A discourse reflects on its own way of speaking

Step 11. Compare with texts to elaborate the discourse as it occurs and addresses different audiences.

Step 12. Select appropriate terminology to label the emergent discourse.

(Burman & Parker, 1993; Parker, 1992)

Appendix 8 Ethical considerations taken during the research

Issue		Ethical procedures
1.	Preliminary papers and authority	The researcher carried documentation to identify themselves to participants. The researcher has been Disclosing and Barring Services (DBS previously CRB) checked. The researcher is a Registered Mental Health Nurse, qualified lecturer and therapist who has training in counselling and group psychotherapy. The researcher has held positions of senior lecturer, operational manager and psychological therapist and is knowledgeable of the standards of practice when working with vulnerable people and keeping safe at work. Permission was obtained from the researcher's employer through the Council Research and Ethics Board prior to commencing the study, and as required from the participants relevant University and/or Council where outside of the researchers employing organisation. The researcher submitted to the University of Northampton Research Ethics Committee the Council's approval on receipt of the approval from the researchers' employers, Cambridgeshire County Council. This research project did not require NHS Research Ethics Approval. The researcher has completed National Research Ethics Service, NHS Health Research Authority: http://www.nres.nhs.uk/ which confirmed this was not required, please see completed form at the end of this table. Reasons this study did not require this approval included; this study was not an NHS study it is a Social Care study, it did not involve NHS patients/vulnerable adults or children, as all participants are Social Care staff. Also, although some social work staff who were approached for recruitment worked within an NHS provision for the purpose of NHS research ethics this did not constitute an NHS site, please see extract taken from IRAS completion notes:

		"NHS or Non- NHS site? 'A research site is defined as the single organisation responsible for conducting the research at a particular locality……The research site is not necessarily the location where research activities will actually take place' Therefore, using this definition Cambridgeshire County Council was the organisation and was the research site.
2.	Appropriate methods	The researcher conducted individual interviews to access the talk of social workers for analysis. The selection of interviews as a method was based on this as the most appropriate means to explore this complex subject, and to allow transparency in the process of gathering source information. The interviews were semi-structured to allow flexibility to respond to the participant. All interviews were conducted by the researcher and recorded. The researcher used a reflexive process to record and acknowledge their position in relation to the research subject and the participants. This was particularly sensitive to issues of power, vulnerability of the participants and impact of the research process on the participants. The researcher explicitly made participants aware of the voluntary nature of participation in the research and that they could have withdrawn without prejudice up to one week from the date of their written consent. However, it was made clear to participants that they needed to notify the researcher within three weeks if they did not wish their interview to be used for analysis.
3.	Choice and recruitment of participant	Participants were approached to join the research initially via an appropriate link person known to the participants, then by the researcher via e-mail, telephone and/or face to face discussions individually or in groups. All participants were adults and professional social workers. On recruitment, they were asked if they have any support needs to participate in the research such as hearing or sight needs.

4.	Involvement	Each participant was given the opportunity to proactively decide whether to be involved in the research. There was no coercion and participants were made explicitly aware that all participation was voluntary and if they did agree to participate they may withdraw up to one week from the date of written consent. Also, if they did not wish to take part this did not disadvantage them in any way or would impact on any other relationship they had with the researcher. A participant could have a friend or a colleague present if they wished during the interview.
5.	Rights and safety, and wellbeing of participant and researcher	An assessment of risk to self and participants was carried out as an ongoing process during the completion of the research to take into account any emergent issues. All participants were qualified professionals, holding positions of frontline mental health social worker and had management responsibility within their organisations. They therefore had experience and training in relation to research and ethical practice. Social workers have particular knowledge of safeguarding and anti- discriminatory practice however all participants were made aware that: - They could withdraw from involvement up to one week from the date of written consent, without fear of repercussions - If they wished to discuss any issues related to the conduct of the researcher, the University supervisory teams contact details was provided It was anticipated that the interviews could cause distress but the researcher was sensitive to the potential power dynamics within organisations and treated all contributions confidentially. The researcher held the post of Head of Mental Health for a Local Authority, and although this was not a direct line management position the researcher had the potential to influence decisions relating to some of the social workers who were approached for recruitment to the study and some who took part. A priority for the researcher was to ensure the wellbeing of these social workers by making them explicitly aware of the voluntary nature of participation. The researcher also ensured that they were aware that choosing either to be a participant or not, in no way

		influenced any other aspect of the relationship with the researcher in their role as Head of Mental Health. All interviews took place within a venue acceptable to the participant and researcher at either's place of work. As both participants and researcher were professionals and subject to their organisational health and safety protocols each took responsibility for their own safety. <u>Strategy for dealing with Participant distress</u> When one participant become distressed during the interview the researcher used their counselling skills and mental health knowledge to evaluate and address the situation. The researcher acknowledged the individual's distress and offer to cease the interview. The participant wished to continue and on completing the interview commented it had been personally beneficial to have an opportunity to discuss being a mental health social worker.
6.	Transcription	Interviews were recorded and transcribed by the researcher. Participants did not automatically receive a copy of their transcribed interview but were aware of the researcher's contact details and that they could request this information if they wished a copy. No request for copies were received.
7.	Consent	Informed consent was obtained - the participant received information in writing regarding the nature of the study, how information would be used, the expectations of their participation and steps taken to anonymise their contribution and to keep it confidential. They had opportunity to ask questions for clarification before deciding whether to participate. Consent from all participants was obtained clearly in writing.
8.	Confidentiality and anonymity	To ensure confidentiality participants were allocated codes for data identification and storage, their personal details were kept secure. Personal contact details will be destroyed at the end of the research unless permission has been obtained to retain them for networking purposes.

		Pseudonyms were used when writing the thesis and names of places and organisations were referred to using general nouns for example the 'NHS mental health services' or the 'Local Authority' to increase anonymity.
9.	Data access	Permission and consent was obtained by informed consent from all participants by a signed consent form.
10	Data storage	Data was kept in a locked filing cabinet and password protected computer when in electronic form. This was in the researcher's office and will be destroyed 2 years from when the study is completed by the researcher. The Data Protection Act will be observed and the researcher will adhere to the data protection policy based on the Data Protection Act of their employing Council.
11	Data analysis and reporting	All participants' details were held confidentially and securely and were anonymised in reporting by the researcher, including the name of the institutions or organisations. In the event that using a name would be relevant to the research and its dissemination the researcher will obtain permission in writing to reveal names.
12	Feedback	The researcher will attempt to contact each participant when the research is completed to ask if they would like a summary of the research study. It is also the intention of the researcher to publish the research findings this will also provide an opportunity for those who participated in the research to respond.

Appendix 9 The AMPH approval regulations

S T A T U T O R Y I N S T R U M E N T S

2008 No. 1206

MENTAL HEALTH, ENGLAND

The Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008

Made - - - - 28th April 2008
Laid before Parliament 7th May 2008
Coming into force - - 3rd November 2008

The Secretary of State, in exercise of the powers conferred by section 114 of the Mental Health Act 1983(**a**), makes the following Regulations:

Citation, commencement and application
1.—(1) These Regulations may be cited as the Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008 and shall come into force on 3rd November 2008.
(2) These Regulations apply to England only.

Interpretation
2. In these Regulations—
"the Act" means the Mental Health Act 1983;
"AMHP" means an approved mental health professional;
"approve" and "approval" include "re-approve" and "re-approval";
"approving LSSA" means the local social services authority in England that has approved the person to act as an AMHP;
"Care Council for Wales" has the meaning given by section 54(1) of the Care Standards Act 2000(**b**);
"General Social Care Council" has the meaning given by section 54(1) of the Care Standards Act 2000;
"LSSA" means a local social services authority in England;
"professional requirements" means the requirements set out in Schedule 1.

Granting approval
3.—(1) An LSSA may only approve a person to act as an AMHP if it is satisfied that the person has appropriate competence in dealing with persons who are suffering from mental disorder.
(**a**) 1983 c.20.Section 114 was substituted by section 18 of the Mental Health Act 2007 (c.12). The Welsh Ministers are making separate Regulations in relation to Wales.
(**b**) 2000 c.14.
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(2) In determining whether it is satisfied a person has appropriate competence, the LSSA must take into account the following factors—
(a) that the person fulfils at least one of the professional requirements, and
(b) the matters set out in Schedule 2.
(3) Before an LSSA may approve a person to act as an AMHP who has not been approved, or been treated as approved, before in England and Wales, the person must have completed within the last five years a course approved by the General Social Care Council or the Care Council for Wales.

Period of approval
4. An LSSA may approve a person to act as an AMHP for a period of five years.

Conditions

5. When any approval is granted under these Regulations, it shall be subject to the following conditions—
(a) in each year that the AMHP is approved, the AMHP shall complete at least 18 hours of training agreed with the approving LSSA as being relevant to their role as an AMHP;
(b) the AMHP shall undertake to notify the approving LSSA in writing as soon as reasonably practicable if they agree to act as an AMHP on behalf of another LSSA, and when such agreement ends;
(c) the AMHP shall undertake to cease to act as an AMHP and to notify the approving LSSA immediately if they are suspended from any of the registers or listings referred to in the professional competencies, or if any such suspension ends, and
(d) the AMHP shall undertake to cease to act as an AMHP and to notify the approving LSSA immediately if they no longer meet at least one of the professional requirements.

Suspension of approval
6.—(1) If at any time after being approved, the registration or listing required by the professional requirements of a person approved to act as an AMHP is suspended, the approving LSSA shall suspend that AMHP's approval for as long as the AMHP's registration or listing is suspended.
(2) Where an AMHP's approval is suspended, that person may not act as an AMHP unless and until the suspension of approval is ended by the approving LSSA in accordance with subsection (3).
(3) Where the approving LSSA is notified that the suspension of the AMHP's registration or listing has ended, the approving LSSA shall, unless it is not satisfied the AMHP has appropriate competence in dealing with persons suffering from mental disorder, end the suspension of approval.
(4) Where the suspension of approval has ended, the approval shall continue to run for any unexpired period of approval, unless the approving LSSA ends it earlier in accordance with regulation 7.

End of approval
7.—(1) Except where paragraph (2) applies, a person shall cease to be approved to act as an AMHP at the end of the day on which their period of approval expires.
(2) Except where regulation 6 applies, the approving LSSA shall end the approval of a person it has approved to act as an AMHP before their period of approval expires—
(a) in accordance with a request in writing to do so from that AMHP;
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(b) if it is no longer satisfied that the AMHP has appropriate competence taking into account the matters set out in Schedule 2;
(c) immediately upon becoming aware that the AMHP—
(i) is no longer a person who meets at least one of the professional requirements;
(ii) is in breach of any of the conditions set out in regulation 5, or
(iii) has been approved to act as an AMHP by another LSSA.
(3) When an approval ends, the approving LSSA shall notify the AMHP immediately that the approval has ended and give reasons for ending the approval.
(4) When an approval ends, the approving LSSA shall notify that fact to any other LSSA for whom it knows the AMHP has agreed to act as an AMHP.
(5) If an LSSA approves a person as an AMHP knowing that that AMHP is already approved by another LSSA, it shall notify the previous approving LSSA.

Records
8. —(1) The approving LSSA shall keep a record of each AMHP it approves which shall include—
(a) the name of the AMHP;
(b) the AMHP's profession;
(c) the AMHP's date of approval;
(d) details of any period of suspension under regulation 6;
(e) details of the completion of training to comply with regulation 5(a);
(f) details of any previous approvals as an AMHP within the previous five years;
(g) the names of other LSSAs for whom the AMHP has agreed to act as an AMHP, and

(h) the date of and reason for the end of approval, if applicable.
(2) The record referred to in paragraph (1) shall be retained by the approving LSSA for a period of five years commencing with the day on which the AMHP's approval ended.
Signed by authority of the Secretary of State for Health.
Ivan Lewis
Parliamentary Under-Secretary of State
28th April 2008 Department of Health

SCHEDULE 1 Regulation 2
Professional Requirements

The professional requirements are as follows—

(a) a social worker registered with the General Social Care Council;
(b) a first level nurse, registered in Sub-Part 1 of the Nurses' Part of the Register maintained under article 5 of the Nursing and Midwifery Order 2001(**a**), with the inclusion of an entry indicating their field of practice is mental health or learning disabilities nursing;
(c) an occupational therapist registered in Part 6 of the Register maintained under article 5 of the Health Professions Order 2001(**a**); or
(d) a chartered psychologist who is listed in the British Psychological Society's Register of Chartered Psychologists and who holds a relevant practising certificate issued by that Society(**b**).

SCHEDULE 2 Regulation 3(2)
Matters to be taken into account to determine competence

1. Key Competence Area 1: Application of Values to the AMHP Role

Whether the applicant has—
(a) the ability to identify, challenge and, where possible, redress discrimination and inequality in all its forms in relation to AMHP practice;
(b) an understanding of and respect for individuals' qualities, abilities and diverse backgrounds, and is able to identify and counter any decision which may be based on unlawful discrimination;
(c) the ability to promote the rights, dignity and self-determination of patients consistent with their own needs and wishes, to enable them to contribute to the decisions made affecting their quality of life and liberty, and
(d) a sensitivity to individuals' needs for personal respect, confidentiality, choice, dignity and privacy while exercising the AMHP role.

2. Key Competence Area 2: Application of Knowledge: The Legal and Policy Framework

(1) Whether the applicant has—
(a) appropriate knowledge of and ability to apply in practice—
(i) mental health legislation, related codes of practice and national and local policy guidance, and
(ii) relevant parts of other legislation, codes of practice, national and local policy guidance, in particular the Children Act 1989(**c**), the Children Act 2004(**d**), the Human Rights Act 1998(**e**) and the Mental Capacity Act 2005(**f**);
(b) a knowledge and understanding of the particular needs of children and young people and their families, and an ability to apply AMHP practice in the context of those particular needs;
(c) an understanding of, and sensitivity to, race and culture in the application of knowledge of mental health legislation;
(d) an explicit awareness of the legal position and accountability of AMHPs in relation to the Act, any employing organisation and the authority on whose behalf they are acting;
(e) the ability to—
(i) evaluate critically local and national policy to inform AMHP practice, and
(ii) base AMHP practice on a critical evaluation of a range of research relevant to evidence-based practice, including that on the impact on persons who experience discrimination because of mental health.

(2) In paragraph (1), "relevant" means relevant to the decisions that an AMHP is likely to take when acting as an AMHP.

3. Key Competence Area 3: Application of Knowledge: Mental Disorder

Whether the applicant has a critical understanding of, and is able to apply in practice—
(a) a range of models of mental disorder, including the contribution of social, physical and development factors;
(b) the social perspective on mental disorder and mental health needs, in working with patients, their relatives, carers and other professionals;
(c) the implications of mental disorder for patients, their relatives and carers, and
(d) the implications of a range of treatments and interventions for patients, their relatives and carers.

4. Key Competence Area 4: Application of Skills: Working in Partnership

Whether the applicant has the ability to—
(a) articulate, and demonstrate in practice, the social perspective on mental disorder and mental health needs;
(b) communicate appropriately with and establish effective relationships with patients, relatives, and carers in undertaking the AMHP role;
(c) articulate the role of the AMHP in the course of contributing to effective inter-agency and inter-professional working;
(d) use networks and community groups to influence collaborative working with a range of individuals, agencies and advocates;
(e) consider the feasibility of and contribute effectively to planning and implementing options for care such as alternatives to compulsory admission, discharge and aftercare;
(f) recognise, assess and manage risk effectively in the context of the AMHP role;
(g) effectively manage difficult situations of anxiety, risk and conflict, and an understanding of how this affects the AMHP and other people concerned with the patient's care;
(h) discharge the AMHP role in such a way as to empower the patient as much as practicable;
(i) plan, negotiate and manage compulsory admission to hospital or arrangements for supervised community treatment;
(j) manage and co-ordinate effectively the relevant legal and practical processes including the involvement of other professionals as well as patients, relatives and carers, and
(k) balance and manage the competing requirements of confidentiality and effective information sharing to the benefit of the patient and other persons concerned with the patient's care.

5. Key Competence Area 5: Application of Skills: Making and Communicating Informed Decisions

Whether the applicant has the ability to—
(a) assert a social perspective and to make properly informed independent decisions;
(b) obtain, analyse and share appropriate information having due regard to confidentiality in order to manage the decision-making process including decisions about supervised community treatment;
(c) compile and complete statutory documentation, including an application for admission;
(d) provide reasoned and clear verbal and written reports to promote effective, accountable and independent AMHP decision making;
(e) present a case at a legal hearing;
(f) exercise the appropriate use of independence, authority and autonomy and use it to inform their future practice as an AMHP, together with consultation and supervision;
(g) evaluate the outcomes of interventions with patients, carers and others, including the identification of where a need has not been met;
(h) make and communicate decisions that are sensitive to the needs of the individual patient, and
(i) keep appropriate records with an awareness of legal requirements with respect to record keeping and the use and transfer of information.

EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations set out a number of matters in connection with the giving by local social services authorities in England of approvals to persons to act as approved mental health professionals ("AMHPs") for the purposes of the Mental Health Act 1983 (c.20).

Before a person can be approved (or re-approved) in England to act as an AMHP by a local social services authority, the person must have appropriate competence. In deciding whether it is satisfied that the person has appropriate competence to act as an AMHP, the local social services authority must take into account that the person has at least one of the professional requirements set out in Schedule 1 and the matters set out in Schedule 2 (regulation 3).

Before a person can be approved to act as an AMHP if he has not been approved before, that person must have completed a course within the last five years that was approved by the General Social Care Council or the Care Council for Wales. The period for which an AMHP is approved (or re-approved) is five years (regulation 4).

Approval (or re-approval) is subject to specified conditions (regulation 5).

The approval shall be suspended for any period that the AMHP is suspended from the register or list relevant to the AMHP's professional requirements (regulation 6).

The approval or re-approval of an AMHP will end when the period of approval expires or before that in specified circumstances. When the approval ends, the local social services authority must inform the AMHP and any other local social services authority for which it knows that AMHP has agreed to act. If one local social services authority approves a person to act as an AMHP who is already approved by another, it must inform that other local social services authority (regulation 7).

Each local social services authority is required to keep records with specified details of AMHPs for whom it is the approving local social services authority (regulation 8).

The Welsh Ministers are making separate regulations relating to the approval of persons to act as AMHPs in relation to Wales.

Accessed from: http://www.legislation.gov.uk/uksi/2008/1206/pdfs/uksi_20081206_en.pdf

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