PRODUCING SINGLE HOMELESSNESS:
descriptive practice in community mental health casework

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Abstract

This is a case study of a community-based interdisciplinary team of Mental Health professionals who work with homeless people in a large English city. Its aim is to 'unpack' the team's decision-making processes. Such processes construct the client as vulnerable in terms of mental health and/or homelessness. The analysis shows the ways in which client description is an organised social accomplishment and is contexted in related research in the sociology of mental illness. Following Goffman (1974) and Gubrium (1989), data are analysed against a background of changing and laminated frames and local cultures. A charge of deviancy is brought and then debated (McHugh 1970). The relation of this analysis to ethical and policy issues is discussed.

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PART I. INTRODUCTION

Chapter One: Setting the scene and aims of the study

This is a case study of a community-based interdisciplinary team of mental health professionals who work with homeless people in a large English city. Its focus is the team's everyday routine practices. Rather than interview them (prospectively or retrospectively) about what they were thinking, it examines what members are doing (Silverman 1993:29). As such, it is a case study within the field of the sociology of mental illness, drawing upon Goffman's (1974) frame analysis.

My overall aim is to 'unpack' the team's decision-making processes. This is a subject worth examining as decisions made by health care professionals have political consequences for patients and clients. Hence, the policy and ethical implications of these decisions will also be considered.

The aims and objectives of this study can only be fully understood in the context of the research setting and of my own theoretical orientations. I will now discuss each in turn.

1.1 The research setting

Throughout the thesis, members are collectively referred to as 'The Mental Health Team' (MHT). This is an abbreviated form of their full designation, 'The Mental Health Team for Single Homeless People'. The team's title has changed several times since the study began in October 1992. 'MHT' has been retained throughout the research for consistency and clarity. The disciplines represented on the team are:

- Medicine and Psychiatry, in the person of a Consultant Psychiatrist (DR)

- Community Psychiatric Nursing (CPN)

- Occupational Therapy (OT)

- Social Work (HU).

The team also has its own Housing Officer (Y). All team members are generically referred to as 'Project Workers'. More detailed abbreviations are to be found in the Appendix at the end of this work.[1]

The MHT evolved from a community pilot study on homelessness which was funded by the Department of Health (DOH) for a three year period from 1987-1990. The present team also receives funding by the DOH as part of the Government's 'Homelessness and Mental Health' initiative. The initiative focuses on the needs of single, homeless, mentally ill people who have little or no contact with mainstream health or social services. The MHT's catchment area is the Waterway Health Authority.[2]

A local Community Health Council survey in this area dating from 1985 ascertained that there were possibly as many as 2,500 homeless people on any one night in Waterway but that bed spaces in hostels only numbered 1,400. The survey also identified no fewer than thirty-one separate organisations who were providing services for homeless people. Its findings concluded that such a fragmented and disorganised approach ran the risk of 'losing' clients between its many agencies. Only broad details of this survey are given here in order to preserve the anonymity of the team's physical area of work. To protect the team's identity, it is not referenced in this study.

Data from a survey on homelessness and mental health conducted between May 1991 and February 1992, which also has to remain anonymous here, suggested that the largest proportion of clients in Waterway are aged between thirty-six and fifty-nine

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[1] Unlike the teams described by Byrd (1981), Pfohl (1978) and Barrett (1996), the MHT did not have a clinical psychologist.
[2] All names are changed throughout the thesis; see 2.3 on ethics.

years.[3] The study commented particularly that, in common with studies in other catchment areas, the team is increasingly engaging a younger client group, especially younger women. Most clients are white and the report states that this reflects 'the nature of service provision for homeless people' in the area covered by the team. The report also identifies that individuals who display what it terms 'odd' or 'eccentric' behaviour represent a significant proportion of referrals to the team. This is put at thirty-four per cent.

Additional Government funding was made available to the MHT and similar teams in 1991 to provide a more specialist service to new hostels which were opened as part of the Department of the Environment's 'rough sleeper initiative'. More extensive work by the team was thus made possible. This included rehabilitation and resettlement work.

The team's service covers three large boroughs in the catchment area. It provides clinical and managerial support to the community teams in these boroughs. The team's housing officer represents it at planning and policy making meetings. The team's role is continually evolving and expanding. Since 1999 it has started to link with Special Needs Housing departments in the area.[4]

When I first visited the MHT in 1990 (or the 'Homeless and Rootless Team' as it then was), it was operating from rather dingy premises overlooked by a multi-storey car park at the back of St. Magna's Hospital. The team was situated in a non-residential borderline space between the hospital oncology unit and a sexual counselling clinic (cf. Barrett 1996:22).[5] Team members were not 'volunteers' as such but they *had* been specially selected. This selection was based on their wide professional experience of working with mentally ill people and their desire to take part in a relatively new venture.

[3] In Byrd's (1981) study, 40% of clients were aged between twenty and twenty-nine, 40% were single, 20% had 'personality disorders', and persons of sixty years and above were under-represented. The average client was either unemployed or an un-skilled worker. Byrd states that her sample is 'generally representative of the population as a whole' (1981:8).
[4] Thanks to the MHT for permitting me to use its information leaflet for this section.
[5] Barrett describes Ridgehaven Hospital as sharing a borderline space between city and country, its nearest neighbours being a home for the intellectually retarded, a state prison, and an abbatoir.

The early work of the team was evaluated well in terms of engaging clients. It moved to larger and better appointed premises in 1992. It was prior to this move in 1991, when the team was on a more secure footing, that its title became 'The Mental Health Team for Single Homeless People'. In 1992, I negotiated access with the team and subsequently began this study. 'Entering the field' is discussed at greater length in Chapter Two.

Since 1992, the MHT has moved premises twice and has had another change of name. Team membership has expanded considerably. The field I describe in Chapter Two relates to their second premises which I call 'NHS Clinic' or 'the Centre'. Of the original nine team members with whom I was involved, only three now remain. The 'Team Leader' designation has been superseded by that of 'Centre Manager'. The holder of this office is a manager from the voluntary sector rather than a CPN. At the time of writing, the present team has less direct clinical involvement with clients than its predecessor. It now concentrates on educative work with staff from a wide range of community agencies exemplifying the Government's 'Partnership' ideal for health and social care as laid down by the 1999 Health Act. Interestingly, when I made my final visit to the team in July 1999 and asked members about their work, all told me that they were still primarily involved with clinical care.[6]

The team's work is monitored and evaluated by an independent agency and members continue to be involved in this evaluation process. It now has its own information technology officer and holds community 'open days' to raise public and professional awareness of homelessness issues.

1.2 Theoretical orientations

This MHT research utilises an ethnomethodologically-informed case study approach (cf. Gubrium and Holstein 1997, Silverman 1993, Dingwall 1981). According to this

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[6] This possibly suggests that the team's identity is so heavily influenced by its practitioner past that it 'downgrades' the educational and managerial focus of its present role.

perspective, members use commonsense reasoning in accounting for cases (Garfinkel 1992). Understandings emerge through members' interpretive interaction. This case study examines members' casework from within as an 'ongoing accomplishment' of the MHT setting (Garfinkel 1992: viii). Their decision-making processes construct the client as vulnerable in terms of mental health and/or homelessness. A charge of deviancy is brought and then debated (McHugh 1970). Following Goffman (1974) and Gubrium (1989), data are analysed against a background of changing and laminated frames and local cultures. Emerging analysis suggests that client description is a practical, organised, social accomplishment. In simpler terms, the team's social practices are locally enacted. Client description is 'tied' to how it is socially organised and produced (Gubrium et al 1982). Following Gubrium (1989), the 'regularities' of casework are:

'organised features of the activities of those concerned' (1989:94).

These assign meaning to team work. In this sense, the team's social practices are a localised culture which represents 'the diverse realities' of the team's everyday work (Gubrium 1989:94). Unpacking the MHT's everyday work is the aim of this study. Gubrium suggests that:

'a local culture provides means of interpreting troubles' (1989:96).

For Dingwall (1996), the management of such troubles is not a trivial matter. Rather, it provides the very preconditions for social interaction.

Following Goffman (1974), meanings emerge through members' use of interacting frames. Opie (1997) refers to such situated practices as being 'ethnographically insufficiently mapped and delineated' (1997:2.2). Although not an ethnography, this case study of the MHT's situated practices adds to accumulating knowledge in the

field of frame analysis. In addition to the work of Gubrium (1989) already cited, I have also drawn on case studies by Peräkylä (1989), Loseke (1989), Holstein (1992) and Atkinson (1995), amongst others. In essence, this study of the MHT's situated practices attempts to address Goffman's question:

'What is it that's going on here?' (1974:8).

This implies a second assumption I make. This is that descriptive practice is informed by local cultures.

Such cultures produce client descriptions which, in part, draw upon the language of psychiatry. The MHT study needs therefore to be contexted in the sociology of mental illness.

1.3 **The sociology of mental illness**

In this chapter, and throughout the thesis, I position my study in the context of other mental illness studies which utilise the concept of frame (Byrd 1981, Pfohl 1978 and Barrett 1996). In the data analysis section of this study, I will make analytic links with these mental illness studies and also with related studies of a more generalised health nature which utilise framing. Such studies include Dingwall and Murray's (1983) research on Accident and Emergency (A&E) departments and Peräkylä's (1989) work in a leukaemia setting. Goffman's concept of 'frame' can be used to unite a range of different studies, all of which have members' practices as their focus (Silverman 1993:28).

Silverman suggests that Goffman's concept of 'frame':

'offers a powerful way to ask questions about observational data'
(1993:50).

Studies which utilise this concept, including the Mental Health Team (MHT) study, can contribute to a *'cumulative* body of knowledge' about 'how framing works in professional-client settings' (Silverman 1993:50). It is particularly relevant to the sociology of mental illness where persons are variously 'endowed with subjectivity or divested of subjectivity' through psychiatric discourse and institutional practices (Barrett 1996:19). Such practices can be made visible through case study research where Gubrium and Holstein suggest:

'talk in interaction becomes the object of inquiry' (1997:54).

In an early case study of a psychotherapeutically-oriented outpatient clinic in Chicago, Doris Byrd (1981) states that:

'the needs of the organization . . . may be as critical to service delivery
as are client needs' (1981:2).

Byrd used observational and written data gathered from the case study to examine the relationship between the organizational needs of the clinic and the fates of the clients. She also collected the diagnosis for each client which was based on the system of diagnosis outlined in the 'Diagnostic and Statistical Manual' (1968) of the American Psychiatric Association (Byrd 1981:18).

Like Byrd, the aim of this MHT case study is not to reject the professional or therapeutic perspective on care (cf. Byrd 1981:2). As Silverman (1997) reminds us in the HIV context, counsellors and other caring professionals are, after all, trying to help us (1997:224). Rather, the aim is to analyse members' routine practices in order to

'unpack' how they make decisions in the context of their everyday work. Leading on from this, the study will demonstrate how the team uses client descriptions of psychological vulnerability to construct the case for accommodation - what Loseke calls 'social problems work' (1989:185).[7]

In addition to the work of Byrd (1981), another American study which examines how psychiatric decisions are socially generated is that undertaken in Lima State Hospital by Stephen Pfohl (1978). Unlike the MHT case study which is small in scale and narrow in focus, Pfohl uses a broad ethnomethodological approach for analysing the diagnostic work of psychiatric professionals. Although much larger in scope, Pfohl too is exercised by the theoretical and applied implications of 'viewing diagnostic work as a practical social accomplishment' (1978:9). However, the overriding issue for Pfohl is how the diagnostic process determines whether or not an individual remains confined in a maximum security psychiatric institution. In the MHT study, the overriding issue is how client descriptions are used by the team to gain accommodation for mentally ill clients.

The MHT case study also has similarities with Robert Barrett's (1996) research which examines the everyday work of the 'Schizophrenia Team' at Ridgehaven Hospital in Australia. Barrett's study focuses on the clinical staff at Ridgehaven. As with this study, staff were members of different professions, predominantly psychiatry, psychiatric nursing and social work, but they acted 'in concert' as part of a treatment team (Barrett 1996:1).

Unlike this MHT study which was only given ethical approval for the audiotape-recording of team discussions but not for the access of client records[8], Barrett was also able to analyse client assessment interviews and how these were documented in case records. By such means, Barrett had the opportunity to:

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[7] See 7.4.
[8] See 2.3 Ethical considerations.

'trace(ing) the transformations that occurred from spoken dialogue to written record' (1996:2).

Barrett argues that the psychiatric hospital is a site where 'common-sense ideas about mental illness are concentrated and refined' (1996:3). I argue that MHT discussions about clients is also a site for the process described by Barrett. However, Barrett is specifically concerned with what he calls the 'cultural logic' that generates and accounts for the various relationships between the 'multiple' manifestations of schizophrenia (1996:3-4), whereas my interest lies in how MHT practice, based on commonsense, constitutes a local culture (Gubrium 1989). Commonsense is itself a 'cultural system' but as it is so taken-for-granted, we often fail to see it (Geertz 1983:92).

Having located this study in the context of research within the field of the sociology of mental illness, I will now discuss why I have chosen a case study approach for the MHT research.

1.4 The case study method

The reasons I had for proceeding in this way were based on two considerations: methodological and practical. I will deal with the practical first. I was given ethical approval for audiotape-recording team discussions, but not for interviewing clients, observing staff interactions with clients, or accessing client records. My choice of research approach, in this respect, was pragmatic. I was also working alone, part-time and unfunded, so again, such considerations influenced my choices.

However, methodologically speaking, case study research, though narrow in focus, permits close and detailed analysis of members' practices as a whole. Team discussions provided me with richly condensed data which permitted me to say a lot

about a little rather than a little about a lot. As accounts and other social practices are 'situated' in character, case study research would allow for analysis of participants' interactions as 'a phenomenon-in-context' (Silverman 1993:203). Far from being 'limiting', by doing a case study, one can:

> *'examine how particular sayings and doings are embedded in particular patterns of social organisation'* (Silverman 1993:205).

In summary, by utilising case study means, it is possible to go beyond the MHT's 'particular set of interactions' as a 'single element' explanation (cf. Silverman 1993:205).

One of the primary reasons I chose case study research was that I wanted to work with naturally-occurring data. Audiotape recording the MHT's weekly case discussions gave me this opportunity. Following Silverman (1993), transcripts of such recordings provide an 'excellent record' of members' interactions as they occur, in situ. Compared to the taking of fieldnotes alone:

> *'recordings and transcripts can offer a highly reliable record to which researchers can return as they develop new hypotheses'* (Silverman 1993:11).

Case study research is entirely suited to the analysis of such 'in-depth' material where the quality of the analysis is the main question (Silverman 1993:22). It has enabled me to analyse the 'sense' of MHT interaction in context.

Seale (1999) examines this point in more detail. Citing Mitchell (1983), he states that:

'The basis of theoretical generalisation lies in logic rather than probability' (Seale 1999:109).

According to Seale, Mitchell recommends choosing the case study for its explanatory power 'rather than for its typicality' (1999:109). Hence, the very idiosyncracy of the case study (rather than its representativeness) can lend a sharpness to the general principles which emerge during the analytic process (1999: 109). In the MHT study, the team's general principle of client confidentiality is clearly demonstrated. However, as Extracts 6:4-6:9 show, this general principle is differently interpreted in cases of client dangerousness. From this, it might be inferred that other clinical teams have similar local arrangements regarding client confidentiality where physical risk to staff and others is posed.

Following Mitchell (1983), Seale (1999) acknowledges that 'logical inference' is possible through case study research. What can be gained by case study methods he suggests, is a 'logical connection' which can be generalised to other case populations. Principally, this is because:

'The validity of the extrapolation depends . . . on the strength of the theoretical reasoning' (Seale 1999:109).

In one sense, this MHT study is much 'narrower' than many others in the field. For instance, Doris Byrd's (1981) psychiatric outpatient study uses quantitative data as a means of gaining a 'concise description' of the clinic's social order. It then uses qualitative data to elaborate these patterns and to 'help disentangle alternative explanations for the findings' (Byrd 1981:15). Glaser and Strauss' (1967) constant comparative method was the model for the qualitative element of her research (1981:15). This methodology was used to analyse data in the form of case histories,

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dispositional conferences and informal interviews (1981:16). Following Byrd, it is a method which requires only 'saturation of data' (1981:16).

Byrd's use of statistical data was possible because of the large numbers involved in the study. Her quantitative sample consisted of 928 adult clients who attended the outpatient clinic between 1971 and 1972. She collected quantitative data on 48 variables - constructing a further 13 from these (1981:17). Her aim in doing this was to uncover a type of structural need which would be generalizable to other client settings (1981:18). This was 'the need to match clients to the number and kinds of treatment openings available' (Byrd 1981:18). Her rationale in using multiple sources was to permit her to 'cross check information' (1981:13). Byrd's rigorous use of the constant comparative method does explain the immediate phenomenon she set out to examine ie. to investigate the relationship between organizational needs and client fates (1981:2). As Seale (1999) says, when applied rigorously, grounded theorizing can 'take researchers beyond common-sense reporting of participants' categories' (1999:96). In the MHT study, by way of contrast, I have made commonsense the very topic of my enquiry. Moreover, as Baszanger and Dodier (1997) point out, we can conduct constant comparison on much smaller data sets than Byrd uses. In addition, Byrd's dependence on fieldnotes (rather than transcripts) and use of data and method triangulation are both open to criticism.

Interesting and wide-ranging as Byrd's study is, it subscribes to the view that if data are gathered in different contexts, then one can somehow arrive at 'an over-arching reality' (Silverman 1993:152). This is possibly where the case study method can be more useful than triangulation, certainly in this MHT research at least. It accepts the context-boundedness of members' talk and uses it to analyse interaction as it occurs so that it is not decontextualised (Silverman 1993:152).

Case study research lends itself to a small field with restricted data access. In addition, as I did not have any prior hypotheses (unlike Byrd who had very definite ideas about the phenomenon she wanted to analyse), doing case study research was highly suitable for the analysis of naturally-occurring talk, however mundane (cf. Silverman 1993:153). By doing a case study, I have been able to examine actual practice rather than accounts given by clients. I have also been able to analyse team interactions as 'meaning-making' occasions (cf. Holstein and Gubrium 1995:80).[9]

Pfohl's (1978) research at Lima State Hospital[10] is comparable to Byrd's (1981) in terms of scale. Pfohl and his team of research assistants was asked by the state authorities of Ohio to research into the diagnostic re-evaluation of inmates designated 'criminally insane'. Twelve interdisciplinary teams of psychiatric professionals were engaged upon this re-evaluation process. Like the MHT study, Pfohl's research also explores 'the practical production of diagnostic assessments' (1978:5). However, Pfohl's concern is chiefly with assessments of dangerousness, whereas mine is with diagnostic assessment in the broad sense although, very often, dangerousness and its assessment is a feature of MHT practice. Again, like the MHT study, Pfohl is concerned with what psychiatric professionals actually *do* when deciding who should be confined as dangerous (Pfohl 1978:4). His work focuses on:

> *'the interactional devices by which evaluators' interpretations are made "objectively" rational and accountable to themselves, to each other, and to the legal agents who commissioned their work'* (Pfohl 1978:7).

Pfohl and his team used field observations, in-depth interviewing and the analysis of transcripts in order to provide 'a detailed account of the interactional work that goes into the production of psychiatric diagnosis' (1978:7). Methodologically, Pfohl's work might best be described as 'a triangulated field study' (1978:63). Like Byrd (1981),

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[9] Further analytic discussion is to be found in Chapter Nine.
[10] A maximum secure institution.

Pfohl had definite ideas about the phenomenon he wanted to examine before he started his research. This he refers to as:

'the theoretical interface between labeling and ethnomethodological perspectives on the sociology of deviance' (Pfohl 1978:8).

By using triangulation, Pfohl's aim was to set up what he calls separate 'vantage point(s)' from which he and his researchers could study the diagnostic process in its 'natural setting' (Pfohl 1978:63). The researchers observed social interaction 'before, during and after . . . psychiatric team members' interviewing of patients' (1978:63). The observers gathered data in the form of their own observational notes and from audiotape-recordings of all talk which occurred during patient reviews (1978:63). Unlike the MHT study in which tapes were transcribed and analysed in the order in which they became available, and until an anomalous case was encountered, Pfohl used *selected* patient reviews (1978:63). This process of selection he calls 'contingency determined sampling' (1978:69). He maintains that the 135 separate cases provides 'a rich base of data' for the analysis of the patient review process (1978:70). But as Seale (1999) reminds us, theoretical sampling is 'potentially limitless' (Seale 1999:93).

When Pfohl's assistants observed the evaluation teams' interviews with patients, they were asked to note 'relevant features' of this social interaction (1978:5). Recordings and transcriptions were also made of selected evaluation sessions. Afterwards, each participating professional was interviewed and asked for his or her impressions, opinions and reflections concerning the patient review process (1978:6).

In Pfohl's phenomenologically inspired work, triangulation is used so that field and interview data can inform each other (cf. Silverman 1993:158). In the MHT research, by contrast, situated action can be uncovered through case study means alone without

having to interview members. Although I *did* present my preliminary findings to members at an early stage this was solely because I was interested in their views. In fact, this generated further data which I could utilise in the analysis.

A case study approach was appropriate for my analytic purposes. It allowed me to analyse mundane talk systematically. It was not reliant on selected or 'exotic' cases like Pfohl's. Nor did it depend on large numbers. Most importantly, it allowed me to emphasise:

> *'the "thick description" of a relatively small number of subjects within*
>
> *the context of a specific setting'* (Rudestam and Newton 1992:39).

Barrett's (1996) extensive Ridgehaven study is more ambitious in scope than either Byrd's, Pfohl's or my own. Barrett recorded observations of daily interactions between patients and clinicians in fieldnotes. He also made audiotapes of interviews in which clinicians assessed patients and recorded case conferences in which patient treatment was discussed (1996:6). By such methods, he aimed to 'burrow underneath medical, psychiatric, and sociological reasoning' (1996:4). In this way, he could:

> *'examine the ideas that constitute schizophrenia, to locate these ideas*
>
> *within Western culture and institutions . . . ' (*1996:4).

By all of these means, he hoped to gain a better understanding of the consequences for those who experience 'schizophrenia'.[11] Overall, Barrett's ethnographic concern was with how people 'made sense' of schizophrenia in the psychiatric hospital setting (1996:7).

Barrett takes Strauss et al's (1964) symbolic interactionist perspective as a 'point of departure' for his study of Ridgehaven. According to Barrett, this is because

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[11] On p.4, Barrett refers to schizophrenia as 'the disorder'. The inverted commas around 'schizophrenia' on *this* page are mine rather than Barrett's.

interactionism fails to deal with 'taken-for-granted ideas of mental illness'. It also fails to deal with 'the broader social and historical location of psychiatric knowledge' (Barrett 1996:10). His preference is for Schutz's (1972) social phenomenology and Foucault's[12] analyses of power and knowledge:

'to provide the theoretical means to address these two issues'
(1996:10).

Like Barrett's ethnographic focus on the taken-for-granted language of professionals in the psychiatric hospital setting, I have been able to focus on the taken-for-granted language of community MHT practice through case study research. As I have already stated on p.18, case study research enables us to explore clinical work as a practical activity. We can examine members' commonsense reasoning. We can also examine the 'tacit assumptions they make in order to process cases and get their work done' (Barrett 1996:13).

Unlike Barrett's work, my more microscopic analysis is also capable of demonstrating how team members are not 'merely' people processers, as Barrett says. Following Holstein (1992), psychiatric and other professionals are also 'people producers'. In Chapter Seven for example, I demonstrate how gender is used by the MHT as an interpretive framework.

Another point of departure in terms of comparison with Barrett's work is that I have not attempted to use Foucault's discourse analysis. Barrett uses 'knowledge about schizophrenia as a discursive formation' to address wider structural issues about power (1996:16). For him, this addresses what he regards as the neglect of an analysis of power 'in both symbolic interactionism and social phenomenology' (1996:16). I did not set out to use discourse analysis as my major analytic perspective. Nevertheless, this detailed case study analysis is relevant to some Foucauldian concerns (as discussed in Chapter Nine).

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[12] Barrett lists Foucault's 'Madness and Civilization' (1967), 'The Archaeology of Knowledge' (1972), and 'Discipline and Punish' (1977) amongst other work. See Barrett (1996:315) for full range of references.

Barrett uses both written and spoken accounts of patients to analyse clinical discourse and to examine how this discourse as a whole:

'*characterizes the patient with schizophrenia as a marginal and anomalous category of person*' (1996:17).

But he is also concerned with macrosocial processes such as analysing the scientific discourse on schizophrenia. His specific focus is on how 'changes in the knowledge that constitutes schizophrenia reflect a changing pattern of institutions that produce and disperse knowledge of mental illness' (Barrett 1996:18). Barrett's methodology then, perfectly suits the objective of his research intentions. In his own words, 'I use Foucault to critique phenomenology and use social phenomenology to critique Foucault' (Barrett: 1996:18).

This is certainly very different to the much narrower case study approach of my MHT study which unpacks the team's decision-making processes through the analysis of commonsense reasoning. Barrett's Foucauldian perspective gives him a specific concern with the production of selves. This is shown in the way he uses 'theoretical tension' to analyse schizophrenia as a 'pathological category of the person' (1996:19). My research interest is not in 'pathological categories' as such, or in how different psychiatric professionals exercise their 'power of definition' in psychiatric assessment (Barrett 1996:300). But by analysing the team's discussions in the way that I have, I can illuminate both the areas identified by Barrett. In the chapter on 'gender', for example, through a process of simple tabulation, I demonstrate how casework is subtly different in male and female cases through members' use of 'family history' (see Chapter Seven).

In the discussion so far, I have identified the aims of the MHT study and positioned it in the context of other sociological studies of mental illness which utilise the concept

of 'frame' (Byrd 1981, Pfohl 1978 and Barrett 1996). I have told the reader why I have chosen a case study research approach. I have compared and contrasted my aims and methodological intentions with the three studies I have already cited. Common features of all these studies, and my own, include:

- a focus on members' practices
- situations involving interdisciplinary teamwork.

A further similarity not so far discussed is a concern with the ceremonial order. As Barrett (1996) states, ceremonies such as the weekly team meeting 'boldly display the values and social processes of the group' (1996:6). Byrd (1981) adds that the clinic is an ideal setting to examine the 'subjectivity of psychiatric enterprise' as it 'increases the range of variation' in staff use of classification and selection techniques (1981:4-5).[13] I am fortunate then, to have been given access to both clinic and account in the form of the MHT's *situated* interactions, for this case study research. They have proven to be a very rich source of data. The study reflects interdisciplinary teamwork at a time of huge change in British community mental health practice in particular, and in health care delivery generally. It also reflects the individual lives of the many single, homeless, people with whom the team interacts.

I will now conclude this introductory chapter with a statement of the key aims and objectives of the thesis. I will also give a rationale for its chapter organisation based on the function of members' frame use in their everyday practice.

1.5 **Aims and objectives**

In the context of a small case study, the overall aim of this thesis is to contribute, methodologically and analytically, to the sociology of mental illness and to the discipline in general. Its key objectives are:

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[13] Silverman describes team meetings as 'scheduled events' (2000:43); see 2.2.

(1) to unpack the team's decision-making processes thereby to compare and contrast the study's methodology and findings with critical studies in the sociology of mental illness

(2) to contribute to the sociological literature on frame analysis

(3) to demonstrate how 'theoretical generalisation' in sociology can be achieved from a relatively small data set.

Having outlined the aims and objectives of this thesis, I will now give a rationale for its chapter organisation based on how members use frames in practice.

1.6 <u>Organisation of this thesis</u>

This MHT case study demonstrates how team members use 'frames' very fluidly to characterise clients and to organise practical action (Goffman 1974). Frames organise both meaning and involvement. They provide an analytic base for managing ambiguity in case talk.[14]

The data analysis part of the thesis begins with two chapters on Constructing the Case in order to provide an 'overview' of case construction processes (Chapters Three and Four). Members describe the problem of homelessness as a 'situationally relevant' characteristic of some mentally ill people (Holstein 1992). Case accounts typify problems that the MHT encounters in its everyday work (Holstein 1992). Constructing clients is an integral part of constructing the case so two chapters on Constructing the Client come next (Chapters Five and Six). Having analysed how the team uses client descriptions of vulnerability to construct the case, Chapter Seven shows the subtle differences in the way in which descriptions are done according to the client's gender. Analysis up to this point is of how casework is done by particular people. The data analysis therefore concludes with Chapter Eight entitled 'Constructing the Mental

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[14] The discussion of frames in this chapter is developed in Chapter Six.

Health Team'. In the final chapter of this thesis (Chapter Nine) the findings of the MHT study are compared to those of Byrd (1981), Pfohl (1978) and Barrett (1996) and other related research. Recommendations for practice are also made.

In summary, this chapter clarifies the relationship between the MHT study and previous sociological work conducted on the topic of mental illness (cf. Rudestam and Newton 1992).

Before turning to data analysis, the 'natural history' of the research project will first be considered.

Chapter Two: The natural history of the research project

The methodological account which follows is grounded in what actually happened in my fieldwork. In this sense, it is a narrative of what I did in the study which, in turn, attempts to document what members actually do in their practice. Hammersley and Atkinson (1989) argue that in utilising narrative skills, the researcher draws on 'everyday' competence. They recommend that this should:

> *'be done in a reflexive manner'* (1989:232).

Using Dingwall's words, the account does not privilege the 'unusual' but describes 'the mundane and everyday' practices of the MHT (1981:129). More recently, Silverman has cautioned against giving too much attention to 'rare events' whilst neglecting more 'common ones' (1998b:112).

Through this account and the data analysis chapters which follow, the reader will learn about the MHT setting, how members organise their work, and how this casework is opened and closed (cf. Silverman 1998b:107). The reliability of the account gains strength through the detail of its description.

Before I describe the process of entering the field, I will discuss how this study was grounded in earlier research.

2.1 Previous research

Reviewing the literature is a critical function of the research process. It helps the researcher to see where his or her work might make a contribution to the area selected. It presents an enormous barrier to writing if the literature review is left to the end. However, *when* it is done depends very much on *why* it is done. In this case study, it is not a self-contained process.

In a sense, reviewing the literature sets 'boundaries' for doing research whenever the researcher decides to start writing. It provides intellectual stimulation. It can be brought into the data analysis as it is needed and can be used to reflect on data on an ongoing basis. It is in this last sense that I make most use of related and supporting literature in the MHT study (cf. Silverman 2000:231). This explains why there is no formal 'literature review' in this work and why it has not been allocated a separate chapter as is common in positivist research. Reviewing the literature in the MHT study is a *continuous* process throughout the analysis.

The earliest influence on this study was Goffman's 'Frame Analysis' (1974). It explores the relational dimension of meaning. For Goffman, a frame is defined by its *use* rather than by its content. Events are seen in terms of 'primary frameworks'. The particular frame used provides a means of interpreting the event to which it is applied. For Goffman, frames are both structural *and* flexible as they are susceptible to change by interacting participants. Indeed, they are highly vulnerable being continually subject to dispute. Chapters Six to Eight of the MHT study utilise Goffman's concept of frame and demonstrate how understandings emerge through members' interpretive interaction.

Data analysis and reading are mutually informing. In a sense, there is no end to updating one's knowledge. In this research, the literature has been used as a continuing opportunity to make connections with the MHT data. For instance, half way through the research the analysis began to lose focus. Reading Holstein's (1992) work on descriptive practice and Loseke's (1989) work on a shelter for battered women provided new knowledge about the accomplishment of social problems work. Similarly, towards the end of the study, fresh material from Kitzinger and Wilkinson (1997) helped me construct the chapter on 'gender' which arose from my reading of Holstein (1992).

All chapters in the MHT study will utilise previous research throughout. Further discussion on the sources cited in *this* chapter and in Chapter One can be found in Chapter Nine which follows the data analysis chapters. This is possibly the most appropriate place in the thesis to situate the literature discussion. As Silverman states:

> *'Until you have done your data analysis, you do not know what will be*
>
> *relevant' (2000:229).*

Having discussed how previous research is used in this study, I will now describe the process of entering the field.

2.2 **Entering the field**

When I began this case study, I had little idea of how I might go about it. I had vague notions of exploring how diagnoses are constructed by health professionals. This was based on my past experience of having a psychiatric liaison role in a unit which linked with an A & E department. Looking at patient admission sheets, I was struck by the number of times I read 'schizo/affective disorder' as the reason for admission to hospital. I concluded that such a cautious descriptor could 'cover' both patient *and* doctor for almost any clinical or legal eventuality. I also had a long-standing interest in the concept of 'illness careers'.

I anticipated that access to the field would be difficult because of the particularly sensitive ethical nature of mental health practice (Fulford and Howse 1993). I made an initial attempt at negotiating access to an in-patient area but this was not successful. In addition, there was the practical problem of matching the demands of full time teaching to the constraints of organisational shift patterns.

Like Silverman's (1987) experience of gaining access to the field of paediatric cardiology ('I was introduced to a doctor at a party', p.3) — my eventual entry to the field of mental health casework was a chance happening. I met up with a former colleague in a local supermarket. After recounting my difficulty in negotiating access to an in-patient area, he invited me to meet the community team with whom he worked. I was both pleased and relieved to have been given this opportunity but I did not recognize it as advocacy at the time. Upon reflection, and many years later, I now appreciate that this was indeed the case.

Following two separate meetings with the team's psychiatric consultant and with the Team Leader (a Community Psychiatric Nurse), I was eventually given permission to audio record the team's weekly case meetings on the understanding that I destroy the tapes when the study concluded.

The choice of team meetings was a deliberate one. These were 'scheduled events' so I did not waste time waiting to see whether or not relevant data would appear but rather, would have them to hand (Silverman 2000:43). Having successfully negotiated access to the field I then became a participant-observer (cf. Byrd 1981:15).[1] I noted that members did not admit to any hierarchical arrangements within the team (cf. Opie 1997:3.5). However, weekly observation of meetings indicated that the chairperson was usually the Consultant.

If the Consultant was not present, the Team Leader assumed the role of chairperson. If neither was present, one or other of the CPN's would fulfil that role. These tended to be the longer established CPN's who were part of the original 'Homeless and Rootless' team. Their community work in the local area foreshadowed the establishing of the MHT. There were no occasions when disciplines other than medicine or nursing assumed responsibility for the running of the meeting. Conversely, fieldwork notes indicate that despite its purported democratic stance, members appeared to hold

[1] Byrd's work begins as a participant-observation study. Unlike the MHT study, she uses qualitative data to elaborate quantitative data on the clinic's social order (1981:15).

informal views on the team's structural 'pecking order'. When asked, members referred to the Consultant as 'Top Cat' after the character in a once familiar television cartoon series. Other members of the team were also ascribed names of characters from the same series, the mention of 'Deputy Dawg' occasioning great mirth. Emerson et al (1995) suggest that such familiar terms of address can often indicate the closeness of members' relationship to each other as well as reflecting their 'relative statuses' (1995:113).[2] In her study of a psychiatric outpatient clinic, Byrd also found a great deal of 'overlap' between occupational and friendship groupings (Byrd 1981:116).

Having noted how members defined their social identities within the team, I also noted how knowledge of homeless people arrived at the Centre. Informal reports from members indicated that it came from three main sources:

- from hospital based psychiatric services in the team's catchment area
- from homeless hostels and voluntary agencies in the catchment area
- and from Social Services.

Information concerning homeless people would be initially accepted or rejected on the basis of a criteria sheet designed to elicit psychiatric symptomatology (cf. Byrd 1981).[3] This was known as 'The Manchester Rating Scale'. This document can be located in the Appendix at the end of the study. Interestingly, although it was in everyday use at the Centre, nobody appeared to know where it originated (cf. Byrd 1981:20, footnote 2 in which she states that nurses do not seem to hold 'clearly articulated treatment ideologies'). The Scale forms part of a broader data collection document which includes questions on the client's homelessness history, accommodation, employment history, family and personal history, forensic history, psychiatric history and medical contact. It also records data on the uptake of financial

[2] The Consultant was always referred to as 'the Doctor', never as 'the Psychiatrist'. This possibly suggests a degree of 'medical gentility' in a potentially stigmatising area of care, but this is a matter of conjecture.
[3] In her outpatient clinic research, Byrd speaks of 'rationing' and 'buffering' as the organizational response modes which are most applicable to input problems. According to Byrd, client selection (rationing) 'may be accomplished by accepting only a portion of those seeking services' (1981:3).

benefits, use of day centres, use of alcohol, drugs and tobacco and whether or not the client has any current involvement with psychiatric services. A case history based on this documentation and any interactions with the client would be compiled by the Project Worker receiving the incoming telephone call. This account would then be presented to the rest of the team at its weekly case conference. No clients attended this conference but some occasionally visited the Centre during episodes of crisis.

As Fulford and Howse (1993) state, any attempt to research into the field of mental health tends to be something of an 'ethical minefield'. So I will now describe how I gained ethical approval and the other ethical issues which arose during my fieldwork.

2.3 **Ethical considerations**

Gaining ethical approval for the study was in no sense 'plain sailing' (Silverman 1987:103). In the early months of 1992, I put forward my proposal to the ethical committee of the Trust hospital to which the team was attached. Apart from stressing the qualitative nature of my research intentions and the fact that staff, rather than clients, would be my proposed subjects, I could only state with certainty that I wished to audio record the team's weekly case conference. In addition, I found the form I was required to complete somewhat problematic. It conformed to the standard type for purely *clinical* research involving human subjects rather than to any proposed sociological research. Predictably, it was very 'physically' orientated.

One question asked for 'potential hazards' and the precautions I might take to meet them. The possible contravening of confidentiality was my written response to this enquiry. I undertook to use pseudonyms for the names of staff, clients and care areas throughout the research to preserve anonymity and to safeguard confidentiality. In the event, even references to months or seasons of the year in the transcripts were changed

as the work got underway (cf. Atkinson 1995:13). Dates of legislation were retained as were dates of fieldwork and any reference to clients' ages. Such data were necessary to the analysis. As it is not usual for a PhD thesis to be published, this further helped to maintain anonymity. In addition, I undertook to write a report on the progress of the study for the ethical committee, should this be required at any stage of the work. As stated earlier, I was not given permission to interview clients or to access their case records.[4]

I guaranteed to keep all audiotapes at home under lock and key and to do all my own transcribing rather than eliciting secretarial assistance. I also promised to destroy the tapes at the end of the study. I did not expect to see or interview clients. Finally, I undertook not to proceed without the permission of all team members following a full explanation of what I proposed to do.

Several months later, I received written consent to proceed with my project from the chairman of the Ethics Committee. I also discussed my proposal with the chairman of the Trust's Mental Health Board, a practicing consultant psychiatrist. He voiced no objection in principle and recommended that I contact the team's consultant and Team Leader to seek their individual permission. This I did in September 1992. The outcome of my meeting with them has already been described.

However, being a participant-observer raises a number of ethical issues which extend beyond formal consent to the research. These issues will be discussed in the section which follows.

Before the research began I decided that the best way to carry out participant-observation both morally and practically, was to be as open as possible with the team. My rationale for making this decision was that this would permit me to be free to ask questions as the fieldwork progressed without creating too much suspicion. Being

[4] See p.14.

open would also permit audio recording of data. To a certain extent this strategy worked, although my insider knowledge of professional practice always made me conscious that what I was being offered of the team's world would be partially restricted. I was aware that my presence in the field might affect the behaviour of those being observed especially as the team was aware of my health professional background. I entered the field in the knowledge that a certain amount of professional self-consciousness would be inevitable but I accepted this as a necessary 'trade off' in terms of access. It was a tacit assumption on my part and possibly on theirs, but on the basis of it, both I and they, were able to proceed.

In this sense, my past experience as a practitioner is in no way 'disadvantageous' to my present role as researcher (cf. Barrett 1996).[5] As a case study researcher, it became useful to me as a source of data. For example, there were almost certainly times in this study when members responded to my presence in terms of what might be called 'ethical correctness'. I sensed that there were some occasions when members overtly displayed their moral adequacy as a consequence of being observed. I can only speculate about this comment which is difficult to validate. It would be beyond the scope of this study to compare cases *I* have recorded and transcribed with those which remain unrecorded and outside of the field available to me. My general *impression* was that members responded to me as a more senior member of staff ie. as an older, experienced professional now working in higher education. I felt that the team's display of moral adequacy in my presence was particularly marked especially where ethical dilemmas were prominent. This is similar to Pfohl's (1978) observation at Lima Hospital. Members reported that the presence of observers made the patient reviews 'more formalized' (1978:71).

As the researcher, I too questioned my own moral adequacy when selecting and interpreting data. Whether or not to include Sandy's case for example (Extract 7:43) became something of a personal dilemma for me as the female caseworker in question had made a special point of telling me beforehand that the case was 'very sensitive'

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[5] Barrett states that being a member of staff facilitated his entry into fieldwork. It gave him 'access to the clinical sphere of hospital life from which a non clinician might have been excluded on the grounds of confidentiality' (1996:xvii-xviii).

(see Fieldwork Notes 2:1). I felt trusted. As Kitzinger and Wilkinson note in their observations on doing feminist research, my concern was that I might be abusing my own power as researcher in relation to that of my subject (cf. Kitzinger and Wilkinson 1997:572 and Emerson et al 1995:145).

Later in this chapter (pp.46-47) I identify and reflect upon my use of the word 'surveillance' as a descriptive category. This descriptor does not actually appear in any of the transcripts. It represents a category which I utilised to describe a case in the preliminary stages of recording as I was writing fieldnotes (cf. Emerson et al 1995:109 on the 'importing' of outside meanings; also cf. Barrett 1996:6).[6] So, ever mindful of my role as researcher, I have considered the 'trusted person' aspect of it very carefully. Despite the feeling of trust, I also felt that the female caseworker mentioned earlier was inviting me to collude in suppressing a story about an unprofessional psychotherapist. On balance, I decided that simply to accept what I was told as unproblematic would have been both naive and idealistic. As Hammersley and Atkinson observe, one can be too 'nice' to one's hosts:

'From time to time one should evaluate whether the research is being unduly limited by such a possibility' (1989:104).

Silverman too points out that over-empathising with one's subjects does not allow sufficient analytic distance (1998b:110).

Following Hammersley and Atkinson's recommendation, I decided that omitting the 'sensitive case' from the completed study would be analytically 'unsound'. By so doing I have taken up Dingwall's early suggestion that, in order to understand a 'collectivity', one must 'deliberately' treat it as 'anthropologically strange' (1981:136). Like Silverman (1998b), Hammersley and Atkinson also warn of the dangers of 'over-identification' and stress that the perspective of the researcher should be 'marginal' and 'reflexive' (1989:102).

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[6] Barrett points out that the researcher's so called 'naked' observations are already subject to interpretive judgements through choosing what is relevant (1996:6). Pfohl too suggests that researchers are 'inherently interpreters' as their reports 'will always be informed by their own efforts to make sense out of what they see happening' (1978:65).

In his Ridgehaven study, Barrett (1996) testifies to the tension experienced in his two roles as researcher and psychiatrist. He states that this often made it difficult for him to perceive the 'taken-for-granted' assumptions of the staff. His 'solution' was to make analytic use of his 'cultural competence' (1996:xvii). Elsewhere, he states that he actively engaged with his subjects, so that he could elicit data that would only be available 'to an accepted member of the group' (1996:5). This was not the researcher role adopted in the MHT study.

Having described the process of entering the field and some of the ethical issues which this involved, I will now examine the researcher's role as participant-observer in the overall context of field relations. As we will see, at this later stage of the research, ethical issues were not left behind.

2.4 **Participant-observation and field relations**

To undertake a case study of 'single homelessness' in the context of full time employment makes heavy demands on the researcher in terms of personal resources and operational constraints. The field is so vast and the nature of subjects' lives so dispersed that I elected to observe professional caseworkers rather than service users, at the outset of the study. For practical reasons then, rather than for others more sophisticated, I became a participant-observer at the MHT's weekly case conferences in October 1992. Fennell et al have also identified this practicality pointing out that participant-observation is:

> 'particularly applicable to situations where people are gathered
> together' (1991:64).[7]

Hammersley and Atkinson (1989) observe that effective participant-observation draws on the richness and vividness of subjects' unnarrated activities, but not their

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[7] By inference, in one place.

decontextualised meanings. In this respect, utilising 'thick descriptions' of the MHT setting is an appropriate approach. Following Seale (1999):

'Readers can then conduct their own 'thought experiment' in seeking to transfer the lessons learned from this setting encountered through a research text' (1999:41).

The issue of generalizability can be raised afterwards and then addressed.

However, Silverman (1993) states that there is a danger in assuming that 'naturally-occurring' data is unmediated. He reminds us that it is mediated by the same cultural forms as any other sort of data (1993:208; also see Hammersley and Atkinson 1989:16 and Dingwall 1981:130). Silverman's note of caution is particularly relevant to my own situation as participant-observer in a field where members are health care professionals like myself. Although I no longer practice directly, what effect this might have on the data is a question I am often asked at research presentations. In terms of the case study approach it is an important question and one which I will now consider. More general points about participant-observation will also be raised.

To suppose that *any* researcher enters a field without past experience or some pre-existing ideas is unrealistic. To suppose that their presence will not exert an influence on the data is equally unrealistic (cf. Strong 1979:229). In my own case, I accepted that my presence in the field would influence that field, but I could not predict 'how' or to what extent. In this sense, data produced by the team were a mutual production which also involved myself as researcher (cf. Emerson et al 1995:106). On a practical note, outside of the meeting the setting was a fairly public one with nursing students and sometimes clients dropping in so that the additional presence of a researcher was probably not that remarkable.

Unlike Strong's (1979) experience of researching in paediatric settings, I cannot admit to being treated:

'as part of the furniture' (1979:229)

by the team members I was observing — possibly because of my practitioner background. However, I *was* aware of feeling more accepted as the fieldwork progressed. This is very similar to Byrd's (1981) experience in the psychiatric outpatient clinic where she reports that at the beginning of her study, members were 'very much aware of an outsider's presence' (1981:14). However, self-consciousness diminished as the study progressed.

I was initially incorporated into the MHT's practical frame (cf. Peräkylä's incorporation into staff use of the psychological frame during his leukaemia ward research, 1989). Members were intolerant of my elected position at the side of the room during fieldwork and 'ordered' rather than invited me to sit with them in their discussion circle even though I maintained a non-speaking role.[8] In the Team Leader's words, this was to 'close the circle'. As Peräkylä surmises about his own role as researcher, maybe this was the best way of collecting data and relating to members in the field (1989:131). Certainly it was of practical use in that I knew the tape was recording data so I was left free to observe and write notes (cf. Silverman 1993:38). However, as Hammersley warns:

'when a setting is familiar the danger of misunderstanding is especially great' (1990:8).

I was aware that I might become too 'comfortable' with the team but upon reflection, this did not happen. Speculatively speaking, constructing a democratic atmosphere

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[8] This was *not* the case for Pfohl's observers who situated themselves unobtrusively in the room whilst observing evaluation teams' interviews with clients (1978:5). Possibly, the presence of clients in Pfohl's study accounts for this difference. In the MHT study, no clients are present. This remains a matter of conjecture.

was possibly also functional to the team in that it positioned me where I could be involved and seen (cf. Bloor and McKeganey 1989:208).[9]

As mentioned earlier in this chapter, Hammersley and Atkinson (1989:98) warn of the danger of 'over-rapport' with members. This, they say, might result in an analytic failure to treat members' perspectives as problematic. The incident from my fieldwork notes of which I have already spoken suggests that at the beginning, I was not accorded full member status. My notes record what Silverman describes as the marking of 'delicate issues' (Silverman 1997:33). Such issues, which may include references to sexual matters, are part of the routine discourse of MHT practice (see Extracts 7:22 and 7:43 amongst others). Marking them as 'delicate' may be accomplished through the use of a hesitation or pause in members' discussions prior to them being raised (see Extract 7:43). But in the early part of the study, raising sexual matters in the presence of a researcher necessitated additional 'caution' (cf. Silverman 1997:64). The demonstration of caution to which I refer pre-empted the telling of the case concerning the possibility of client sexual abuse by a psychotherapist unconnected with the team (see Extract 7:43). The female CPN who eventually presented the case spoke to me in the following terms before the meeting convened:

Fieldwork Notes 2:1

CPNC: Some of the things I'll be talking about are very sensitive

This interaction took place in the kitchen as we prepared coffee for the meeting.[10] It was the only private space available at the time and one in which the CPN took the opportunity to 'do' caution.

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[9] Bloor and McKeganey's (1989) study describes 'Think Day' at 'Beeches', a halfway house for disturbed adolescents. Resident participation in this day helped to construct the régime of the organisation as a 'democracy' in residents' eyes.
[10] See 7.1 on the traditional caring role of women.

Silverman (1993) suggests that social context can pressure practitioners to communicate in a 'particular direction' (1993:192). It would be wrong to generalise from such a limited extract of fieldwork but I tentatively suggest that the communication format utilised by the CPN mirrors the 'individualist focus' of CPN training (Sheppard 1990:78). Such an approach functions to create a social space in which social matters such as delicacy can be done. The character of the case is constituted as 'sensitive' by its being invoked in non-specific terms. We have no knowledge of what 'things' the CPN will be talking about although we infer that they might be sexual in nature. That the interaction occurred between subject and researcher indicated to me that the boundaries of access to the team's private world required ongoing negotiation.

My relationship to members throughout the study was one of marginality punctuated by moments of closeness. Peräkylä (1989) suggests that the researcher's relationship to those being observed *must* change as analysis progresses following data collection. In my own circumstances, this occurred after I started transcribing.

Transcripts in their raw form were sent to the team and comment was invited at a subsequent meeting. Amusement appeared to be the initial reaction closely followed by observations and comments which indicated that members had discussed the content of the transcripts amongst themselves before agreeing to discuss them with me. The Housing Officer for example drew attention to the widespread use of medical terminology in the transcripts. She reported that this use of professional jargon made her feel excluded and caused her annoyance (cf. Opie 1997:10; also cf. Barrett 1996:97). Fieldwork notes record her request for the adoption of 'plain English' during case discussions:

Fieldwork Notes 2:2

Y: Heh — can you guys speak in plain English please? It's not nice to keep asking [for clarification]

Y cited the transcripts as evidence to emphasise her point — looking in the direction of G who was reading a transcript before the meeting began. Her request was then verbally acknowledged by the rest of the team. When members slipped back into professional 'shorthand' at subsequent meetings the occasions were accompanied by a repair ie. by post-hesitation and apology. My interpretation of this phenomenon is that team identity, like team access, is subject to ongoing negotiation and review. This inevitably changes the situation through the research but these changes can be topicalised and lead to new research insights (see pages 34-35).

A number of other discussion points arose out of the team's reading of the transcripts which in turn, yielded additional data about the team's philosophy and practice. For example, my observation that occasionally rules were 'bent' to accommodate clients was received somewhat negatively. Members' response to my interpretation of the data was to emphasise that the team always acted professionally towards clients and that 'bending the rules' sounded sinister. Although there was momentary misunderstanding here, the ensuing debate about the team's professional role was a positive one. The issue of what *might* be fed back to participants is discussed at greater length in Chapter Nine. Participants' view of *my* role, already raised on page 34, might also promote an interesting dialogue.

A further point which generated critical interaction between members was that of client selection. Again, it was Y, the Housing Officer, who raised the point, asking the team: 'Why do we discuss some clients and not others?'

As in this case, members' responses are focused on practical and ethical issues. As the researcher, it was not my intention to intervene in practice, nor would it be appropriate for me to do so. However, inviting practitioners to discuss fieldwork data generated through their own practices can and did provide:

'the basis for a fruitful dialogue' (Silverman 1993:194).

The initial diffidence about my presence disappeared almost entirely following informal data discussions with members of the team. They became more actively involved in the process. They went to great lengths to correct what they regarded as any misinterpretation on my part. On balance, I considered that this was preferable to imposing *my* social reality on them. On one occasion I enquired about client autonomy and to what extent clients were at liberty to discharge themselves from care. The immediate response was to convey that this was possible although members appeared surprised by the question.

The following week a client was selected for discussion who had reportedly 'sacked' his caseworker (see Extract 8:69). I will never know whether this was coincidental or whether my question had actually *prompted* this action from the team. In a sense, the invoking of the 'sacked caseworker' story demonstrates some of the advantages of participant-observation as a research method. In seeking to understand the social world of the team my enquiry had left members free to enact their identity as caring professionals. As participant-observer, I had the opportunity to record how the story was done by members. It also enabled me to explore the setting in which it was done. Members displayed team fairness and advocacy through the telling of the 'sacked case worker' tale.

Participant-observation also permitted me to spend an extended period of time in the field which I consider to be an additional strength of the method. For a small scale, in-depth study such as this, the extended time factor allowed for new perspectives on the emerging analysis. A new hypothesis about the emergence of an economic frame was generated by this approach. The method also enabled me to examine in more depth the consequences of members' use of frames (see 7.4).

I now want to examine the process of data collection and the use of analytic induction as a research method.

2.5 <u>Data collection and the use of analytic induction</u>

Having achieved access to mental health casework, my starting point was to observe and record what members were saying and doing in their meetings about clients. This focus on members' activities generated initial questions about what they had to know to do their work. It also built on my original interest in diagnostic construction. I audio recorded this 'naturally occurring data', and made handwritten fieldnotes of my observations whilst the tape was recording. This enabled me to record visual data that might otherwise be lost or unavailable to me if I relied on the audiotape alone (see discussion on pages 44-47).

A total of twelve meetings lasting approximately seventy-five minutes each were recorded between October 1992 and January 1993.[11] A further three were recorded between April and May 1993. The first meeting was 'lost' due to problems with the tape recorder. Forty-five client stories were available overall. Of these, thirteen were fully transcribed and four were partially transcribed. The shortest transcript was only three pages long. This later turned out to be a deviant case (Extracts 6:49-6:57). The longest ran to eighteen pages (Extracts 7:26-7:32 and 7:34). One hour of recorded team interaction took an average of ten hours to transcribe (cf. Atkinson 1995:10). Transcription devices and methods will be described at the end of this chapter (see 2.6).

A total of forty-five hours was spent on data collection overall. This included twenty hours of recording and twenty-five hours of participant-observation. No selection process as such was involved in the transcribing of complete accounts. Accounts were transcribed in chronological order which equated with the time frame of the fieldwork. It was only after the two phases of fieldwork were complete and I constructed the broad categories upon which my preliminary analysis was based, that I began to examine extracts rather than whole transcripts. In this sense, my work differs from

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[11] Byrd's case presentation length averaged only four minutes (1981:10). This was because it was oriented towards 'a brief assessment of the problem and a dispositional recommendation' (1981:9).

research which appears to be based on the use of 'favourable' extracts only (cf. Pfohl 1978:63). By using extracts in this way, I attempted to find 'the sense' of what members were saying, and what was *made* of what they were saying. I then shifted my emphasis to the discourse-based question: 'How do participants *do* things?'

I will now describe the physical environment in which team meetings took place and were recorded. I noted that there were no clients in the room during the meeting and that members sat in a circle in easy chairs roughly positioned around a low coffee table. The only window in the room faced away from the main road and over a garden. The road beyond that was some distance away so that noise from passing traffic was evident but not obtrusive. The window was hung with net curtain. The door generally remained closed throughout the meeting. The absence of interruption from telephone calls and bleepers suggested that the receptionist outside had been charged with taking calls whilst the meeting was in progress. Writing activity by the team was restricted to the member presenting the case at the end of the discussion although several members carried pens and nctepads. The researcher took fieldnotes throughout. Otherwise, this was a space segregated from public view.

Note taking enabled me to document episodes of 'back chat' and laughter which were not always clearly identified on the tape. Whispering, for example, could not be deciphered but could be observed. Such episodes appeared on the transcripts as 'background laughter' (see Extract 8:69, Ls.25, 38 and 40) or any other descriptor which most adequately represented the action observed. Barrett (1996) also observes staff members setting up 'side conversations' with those sitting adjacent to them in his Ridgehaven study (1996:80). Like the MHT study, Barrett's meetings were informal and without a written agenda.

Being able to see as well as hear, what was going on provided an extra dimension to the gathering of data. I could at once record the team's proceedings *and* view the

'unique strategic properties' of its performance (Schieffelin 1998:198). Members' behaviour indicated that they slotted in and out of the main discussion in terms of giving attention to it. However, nobody ever left the room before a case meeting was over. As such, all team members were a customary part of the action although, as transcripts demonstrate, a small core of long-standing players did most of the talking.

In this sense, the 'live' performance differed from the transcript-text in that it was a uniquely situated occasion. Schieffelin speaks of the 'ephemeral' nature of performances which:

> *'create their effects and then are gone — leaving their reverberations*
> *(fresh insights, reconstituted selves, new statuses, altered realities)*
> *behind them' (1998:198).*

The case study as text is examined in more detail in Chapter Nine.

Pfohl's (1978) observers in the Lima study were also able to describe 'a wide range of non-verbal interactional issues' (1978:64). However, unlike the MHT study, their conversations with clinicians about such interaction were done retrospectively rather than being analysed in situ. In addition, Pfohl's observers had been given preparatory training sessions in 'what to look for' whilst observing. Interactional gestures which suggested 'deference' or 'dominance' were to be especially identified (1978:65). This was not part of the research process in the MHT study.

Note-taking also enabled me to record non-verbal action and background noise such as doors slamming, chairs being moved, or in one instance, a member putting his feet on the coffee table. This last action resulted in the knocking over of a metal vase containing flowers which had been placed in front of the tape recorder possibly in an attempt to render it less visible.

There were no occasions whilst I was present when members walked in late to the meeting although there were numerous occasions when meetings had ended where members stayed on. These 'secondary' meetings were not tape recorded but fieldwork notes were made when possible. My assumption was that, in proceeding this way, I could understand the phenomenon of the team's work through the activities of its members in its own setting (Silverman 1993:37). However, I was aware that I was only permitted to tape record the 'primary' meeting and that members waited for me to leave before engaging in their more informal discussions.

At the outset I made my own broad descriptive headings for each case account. These were based on the member's introduction to the case which invoked both age and gender. An example of such a heading was:

'Fifty year old woman who has just been accepted by a hostel in the local area'

I tried to make the description as 'flat' as possible, but found on later inspection that in many instances I had provided my own summary of the opening presentation. The heading was intended to be an identification device for differentiating the transcripts and for matching them to the accompanying fieldnotes. This demonstrates quite clearly that even in the role of note-taker, my recording skills as a fieldworker are influenced by my practitioner past. A similar observation is made by Emerson et al (1995). They suggest that 'prior experience, training, and commitments' all influence the way in which the fieldworker writes notes (1995:42). I had other surprises. One heading read:

'Surveillance of a twenty nine year old man in a hostel who is preoccupied with religious tapes'

Listening to the tape again and re-reading fieldnotes at a later date demonstrated that the word 'surveillance' was not actually used by the narrator of that account. The heading represents my own, broad, descriptive category.

Another observation was that these headings accounted for Ls.2 and 3 of all the accounts transcribed which explains why members' talk invariably begins on L.4. L.1 is always the name of the setting in anonymised form (NHS Clinic) followed by the number of the tape and the date of the meeting. L.2 gives the number of the account in chronological order. This represents how the transcriber worked eg.

1   NHS Clinic: Tape 3: Friday October 30th 1992

2   Case 3: The drawing of everyone's attention to the existence of a psychotic male

3   hostel resident

The time the tape was turned on was documented in fieldnotes as was the time it was turned off. This organising practice reflects the temporal order. However, as Hammersley and Atkinson remind us, the presentation of data following transcription does not unfold in such a 'neat sequential fashion' (1989:215). In all instances, L.4 represents not the beginning of the account as such, but the beginning of members' talk *after* the heading had been written. Again, this did not demonstrate the actual beginning of talk but the *permitted* recording of talk. Members asked that I did not turn on the tape until they were ready. As a case study researcher, not only was I an observer of the field, I was also an element within it (cf. Atkinson 1991).

I attempted to transcribe as much as I could of what was said and to record in fieldnotes the setting in which this social activity took place. After transcribing a total of six accounts in full, I began to identify recurring instances in the raw data. These broad, analytic categories are listed, crudely, as follows:

- client vulnerability
- deviancy and commonsense reasoning
- character work
- 'distancing' of other professionals/agencies
- bending the rules
- interchangeable roles.

'Client vulnerability' and 'deviancy' appeared to be topics of concern for MHT members. The remainder of the list was generated after noting instances of the first two categories when they emerged in the transcripts. No computer software package was used in this process. This had advantages as well as disadvantages (see 9.4.2) in that the initial categories remained very flexible eg. the last category was set aside as it served no immediate analytic purpose (cf. Emerson et al 1995:157).

I had audiotapes, transcripts and field notes which gave me limitless opportunities to return to my original data and redefine the categories as the analysis progressed. Through such means, I was able to test out emerging hypotheses about members' commonsense reasoning generated by fieldwork. It was at this point that I attempted to construct a model which I later rejected because it was too rigid to explain the complexity of members' social action (see discussion on pages 223-225).

I was also able to consider instances in the data which contradicted the emerging hypotheses (Silverman 1998b:112). One such instance was the account in which the client was not directly taken on by the team. This anomalous case is analysed in Chapter Six.

Statistical measures were not used in the analysis overall. However, counting the number of times 'family history' was invoked in members' accounts threw new light on gender as an interpretive frame. Hammersley and Atkinson suggest that in the

discriminate use of numbers, 'quantification' can be used as an 'aid to precision' (1989:19). In *this* study, counting is used to examine a hunch.

I now want to move on to consider transcription devices and methods. In this section, I will explain, discursively, why the transcript extracts appear in the form that they do. I will also discuss what bearing the transcripts have on my chosen methodology.

2.6 <u>Transcription devices and methods</u>

Throughout this study I have recorded my observations through fieldnotes and audio recordings of naturally occurring data. The practical and methodological advantages of collecting data by such means is discussed in Chapter Nine. I chose to collect data in the way that I did because it was/is appropriate to the study of situated action. Audio tapes provide detailed recorded talk which fieldnotes alone cannot provide (Silverman 1993:117). Following Silverman, preparing transcripts is itself, a research activity (1993:117).

The transcription notation for this study is to be found in the Appendix following the concluding chapter. Quoting Atkinson (1995), the act of producing the transcripts was 'not a straightforward matter' (1995:12). In the main, they were constructed according to my own commonsense reasoning as I had no precedent for the process of transcribing. Because of this, transcripts do not always conform to accepted conventions. However, there is no perfect transcript and what I have adequately serve my analytic purposes.

The practicalities of audio-recording multiple voices in a less-than-soundproof environment exerted certain constraints. It was not possible to denote overlapping voices for example. Neither was it possible to decipher the simultaneous secondary

interactions which frequently occurred alongside the main action. I tried to transcribe what I heard as faithfully as possible using standard spelling and punctuation so that members' accounts would not appear 'unnecessarily odd' to the reader (Atkinson 1995:12). I did not attempt to represent accented talk. I have retained clinical abbreviations where they occur eg. GU[12], HIV[13], as I wanted to maintain as natural a record of what members actually said as was possible in the situation described (cf. Pfohl 1978:79). I have also retained abbreviations for professional roles or qualifications as they were presented in the spoken account. Reference to RMN for example represents 'Registered Mental Nurse'. For the benefit of the reader, full descriptions are put in brackets immediately following the abbreviation or are footnoted.

There was no specific reason why I used square brackets in the transcript extracts and round brackets in the surrounding text except an aesthetic one. Square brackets tend to be 'bolder' when used in more compressed text. This makes them more prominent so that they stand out amongst the smaller typeface. Line lengths conform to the width of the A4 page leaving the conventional margin. It was not particularly necessary to leave a space between speakers in extended interactions involving multiple parties (see Extract 8:69). As with the choice of square brackets mentioned earlier, it simply makes the transcript easier to read.

Lengths of pauses were not timed exactly. Fieldwork observation demonstrated that the talk was generally unhurried, even 'leisurely', and that it was frequently punctuated by laughter. I approximated the duration of pauses as being in the range of one second for the shortest, 'um', to almost four seconds for the longest, [long pause]. An arrow in the left hand margin pointing to a numbered line of transcript indicates material which is discussed in the surrounding text.

The transcripts then, cannot be perfect. However, for case study research analysis, they serve the purposes at hand. They capture sufficient detail of the MHT's actual

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[12] Genito Urinary.
[13] Human immunodeficiency virus.

practice. They record the team's interactions in situ. They can be re-interpreted. They can be offered to other researchers as a means of checking reliability. Atkinson, amongst others, makes some interesting observations on the use of transcripts. He suggests that:

'The tension between reliability and fidelity is a recurrent issue for ethnographic analysis and there is no pure or perfect mode of representation' (1995:12).

I discuss this point in more detail, in the context of case study research, later in the thesis (see Chapter Nine). Hammersley (1990) also doubts the possibility of capturing 'the full potential variation' of data, even when a *range* of ethnographic methods are used (1990:30). As I have already mentioned, although the present work is not an ethnography, case study research poses similar analytic and methodological dilemmas as those suggested by Atkinson (1995) and Hammersley (1990).

With hindsight, I might use more conventional transcription devices if I were to do the transcripts again. This would save the 'creative' work of devising my own. However, lacking the quality of recording more commonly associated with Conversation Analysis (CA), it remains a matter of debate as to whether this could have been a practical option. From a methodological perspective, I did not need the fine detail required by those working with the CA method. What was available to me enabled a reflexive approach to the study so that it was possible to discuss methodological issues as they arose. This reflexivity permits talk about such issues rather than concealment. It does not alter the validity of what has been produced.[14]

Having recounted the 'natural history' of this case study research, I will now describe the analysis of data. The first of the data analysis chapters is entitled 'Constructing the Case I' and it is here that I begin my account.

[14] A reflexive position is also taken on the use of previous research in this study (refer to 2.1).

PART II. DATA ANALYSIS

Chapter Three: Constructing the Case I

Mental Health Team members produce case accounts in narrative form. These verbal accounts can be viewed as retrospective constructions of the caseworkers' 'stories' which are abstractions of their clients' actions and lived experience (Atkinson 1991). These caseworker 'stories' have many levels but are commonly arranged in ways which denote the client's vulnerability.

'Doing vulnerability' appears to be a consistent element in MHT narratives. It constitutes an essential 'building block' in the team's construction of the client. However, vulnerability in itself does not produce the grounds for casework. Clients' actions are also debated. The way in which members do this will now be discussed using the account of deviance provided by Peter McHugh (1970).

McHugh makes a distinction between actions which are 'conventional' ie. where choices are perceived to be possible, and actions which are 'non-conventional', where choices are perceived to be constrained. In a conventional situation, team members debate whether or not the client's actions are inevitable. On the basis of such debate, the team reaches a decision about the inevitability (or otherwise) of the client's actions. If team members decide that clients know what they are doing, then their actions are defined as 'theoretic'. If so, a charge of deviancy can be made (McHugh 1970:164). In other words, if it can be demonstrated that the client was behaving as a practical actor and knew what (s)he was doing, then (s)he would be held responsible. If not, then (s)he will not be held responsible. For McHugh, deviance is the 'upshot' of the social processes of 'conventionality' and 'theoreticity':

> *'because they produce the designations of deviance which follow them'*
> (1970:170).

As we shall see shortly, in Chapters Five and Six, I will show how these issues become important when the MHT defines its clients. In MHT casework, issues of conventionality and theoreticity become important constitutive elements of the case.

Narratives of clients as told by team members are dynamic phenomena in which client actions are constructed in moral terms.[1] Typification of clients as 'good' or 'bad' is constituted through members' debate. Team members offer 'exemplary' case histories to contextualise their casework. These are selected case histories from which other MHT members can learn or with which they might help. They orient their audience to the case by grounding its opening in terms of 'reasons' which are collectively understood by the team.

This part of the chapter will be divided into two separate sections: 'opening the case' and 'typicality'. How the team does opening, and how it constructs the typicality of the case both contribute to a client definition of pre-theoreticity. How the team does closing is built on how it does opening. It is a more complex activity so discussion on closing is allocated a separate chapter (Chapter Four).

3.1 <u>Opening the case</u>

Opening the case is 'heard' as an account of the 'teller's' competence in selecting clients appropriately (cf. Holstein and Gubrium 1995:19). An example of a typical MHT case opening is given below:

Extract 3:1

4 CPN2: . . . The reason I want him discussed is because — uh — that he's on
5   his final warning at Scotsway basically, and I think — do some more, or whatever.

[1] The practice of morally evaluating patients is also central in Barrett's (1996) research. However, it appears to have a different function at Ridgehaven in that staff use it as an 'objective of treatment'. This objective is to 'transform a case of schizophrenia into a person who (can) be held responsible for his or her actions' (1996:144). Barrett notes that patients are accorded volition when staff talk about them at meetings but are seen as being influenced by forces lying beyond voluntary control when 'rendered into a written case format' (1996:143).

The client's situation would be 'heard' as being one of 'risk' as losing his hostel place would make him homeless. CPN2 offers it as a 'reason' (L.4) for bringing the client to the team's attention. It serves to endorse CPN2's role as both a caring professional and as a competent member of the MHT. The CPN is 'doing' vulnerability in accounting for this case selection. This is a familiar interpretive category for MHT work and one which underpins its philosophy of care as service providers. It is a commonly encountered feature of MHT case openings as illustrated by the following data extract:

Extract 3:2

4 CPNC: Right — okay— um, well the first client I want to discuss is somebody called Sandy who
5   was referred to me by Trudy at the Rockwell Centre, and she was first referred to me in
6   March of this year, who thought that Sandy was depressed, and that she wanted to talk to
7   somebody, and um — so she came to the Rockwell Centre and I saw her there

The possible presence of mental illness provides the grounds for presenting the case (L.6). It also fits the team's organisational and administrative reality in that the case has been officially referred to the team from a day centre with which they regularly liaise (L.5). In this sense, MHT casework is similar to Byrd's psychiatric outpatient casework where practitioners' accounts contribute to organizational integrity (1981:142).

Case openings 'do' much more than merely introduce the case. They account for client selection and presentation. They assign competence to the narrator as the 'teller' of the case (cf. Holstein and Gubrium 1995:19). They provide grounds for the institutional practices of the MHT. They give an early and 'economical' indication as to the appropriateness of the case so may be viewed as important components of competent case accounting within the team's culture. Following Atkinson, in common with purely medical case narratives, they serve to construct the case account:

> '*in accordance with the schemes of relevance that relate to the audience*' (1995:97).

Recent sociological literature on casework across a range of different fields sheds light on the local production of accounts. Pithouse and Atkinson (1988) for example look at case accounting in a social work context. They suggest that 'unobserved encounters' between individual case workers and their supervisors find 'meaning' through the interaction so that accounts of casework *are* work in a sense — a 'good' account testifying to 'good' work (1988: 198). The professional social worker deploys rhetorical skills when recounting the case which are 'constitutive of the worker's expertise' (1988: 198). In a different context — that of neonatal intensive care units — Renee Anspach (1988) observes that there are significant consequences for physicians contingent on the language of case presentation (1988:357). For Anspach, case presentation is:

> *'an arena in which claims to knowledge are made and epistemological assumptions are displayed, a linguistic ritual in which physicians learn and enact fundamental beliefs and values of the medical world'* (1988: 357).

Atkinson (1995) researches doctor-doctor interaction in haematology settings in order to explore how patients are constructed as 'objects of a medical discourse' (1995: ix). Quoting Friedson (1970) he acknowledges that clinical knowledge or opinion is grounded in characteristic ways of seeing and legitimating (1995: 47), but that decisions made may also be debated, negotiated or revised by medical groups or teams in different settings (1995: 52). For Atkinson:

> *'each social setting in the organization of the clinic will generate its own information'* (1995:52).

Atkinson (1995:54) sees clinical decision-making as a 'collective organizational activity' which is 'shaped by social influences'. For him, it is not 'the outcome of individual minds' (1995:54). This collective organizational activity hinges on

'socially shared discursive resources' which are locally manifested (1995:54). He later refers to these as 'the everyday ceremonies of medical work' (1995: 59). He explores how language is used in haematology work to 'narrate the facts of disease and illness' and how it may be used to 'persuade fellow practitioners as to those facts or opinions' (1995: 59). He sees the 'language of the pathological gaze' in the field of haematology as constituting 'a socially shared collection of conventions' or cultural resources for the production of facts (1995:70).

A further example of how the MHT opens a case is given next. This will be followed by a discussion on how cases are shown to fit MHT concerns.

In Extract 3:3, the client 'that is causing major problems' (L.4) is presented by OT, the team's occupational therapist — who elects to speak first:

Extract 3:3

3 G: Who's got one then?

4 OT: I've got somebody that is causing major problems

➜ 5 G: You've got somebody you need to mention?

➜ 6 CPN2: I've got one I need to mention

7 G: I've got one that I just want to mention briefly

G's utterance on L.5 and CPN2's utterance on L.6 provide the grounds for description. CPN2 and G also have clients they wish to present but observe the 'queuing' rule once OT has started. OT takes precedence on this occasion — team members 'hearing' that her client is a priority ('I've got somebody that is causing major problems', L.4). Like Turner's (1972) research on the procedural relevance of 'beginning' in psychiatric group therapy meetings, OT is designated as the 'authorized starter' (1972:395). She uses the turn of talk which is made available to her on L.8 (not shown).

Having shown how the case opens, the issue which will be identified in this part of the research is how the case is shown to fit MHT concerns. This issue is represented in the case extracts which follow. It represents a general feature of all MHT case accounting:

Extract 3:4

4	CPNC:	Could I — briefly mention something?
5	Y:	Go on

→ 6 CPNC: Um, well it's very, um, an issue that came up at Hope House [hostel] and I wanted just to
→ 7   see if other people had this happen and whether they/how they dealt with it. Um, I've
8   been seeing two or three men who are, uh, clinically depressed and who are actually um
9   — have been seen by Dr L a couple of them, and have been treated for depression. And a
10   couple — two of them are quite sort of 'retarded' and, you know, very seriously depressed
11   and, um, were both on antidepressants. And um — what's happened with them is that
12   they've become very withdrawn, and all the things you might imagine with people who
13   are depressed — and, um, have been sort of [slight laugh] — [pause] — 'snatched' by the
14   Resettlement Officers and sent down to the South Coast quite quickly when they're not in
15   a sort of 'position' to sort of [   ] — go to the South Coast, and if you are terribly low I
→ 16   suppose you'd go, and both times with disastrous consequences in that they, you know,
17   just become more and more depressed and haven't got their medication and haven't been
18   keeping to, uh, local services, and ended up coming back again because the homes
19   couldn't cope with them. And this has happened again with a man who is — is — who
20   has got sort of, a major depressive illness, and for the first time they've actually discussed
21   with me whether I think this is a good idea for him to go, and I've said 'no'. But the client
22   himself, who's — very sort of — 'passive' and and — very — very low mood is sort of
23   saying: Well, didn't really care what happened to him because he was very sort of, so low.
24   And he's saying: Well, I don't care, sort of thing — it'll be peace and quiet sort of thing
25   after Hope House. And I think, you know, at the moment, he's seeing um, Dr L regularly
26   and she's sort of monitoring his — his, um — illness — I feel like he's quite well linked
27   into services, and I go and see him. I don't think it's the ideal place for him to be in,
28   obviously, but he's not in a position really to decide about, um, where he goes. But he's
29   actually saying: I don't care, you know — send me if you like, so it's almost like I'm saying
30   — *I* think he should stay in Hope House, but I don't think it's ideal. Dr L doesn't think
31   he's bad enough/or really have the bed space to put him into hospital, um I'm not really
→ 32   sure. His depression isn't really lifting. So, I just wonder if other people have that
→ 33   experience with the direct access hostels and how — they deal with it, and how
34   we/I mean — I do feel I'm railroading over what this man's actually saying — 'cos he's
35   not strongly saying: I want to go to the South Coast, but he's just saying: Well, you know,
36   I don't care. I'd rather be dead than alive, sort of thing

CPNC's utterance on Ls.6-7 constitutes the Hope House issue as a topical event. On L.16 she constitutes herself as a knowledgeable describer with her allusion to 'disastrous consequences'. The male client in the account is constructed in terms of mental illness:

Extract 3:5   (Part of Extract 3:4)

19 CPNC: couldn't cope with them. And this has happened again with a man who is — is — who
→ 20   has got sort of, a major depressive illness, and for the first time they've actually discussed

The description has additional impact as it is heard in the context of an ongoing situation at Hope House hostel where vulnerable clients are being transferred to the South Coast before they are fully recovered. In Extract 3:4, CPNC paints a picture of clients who are 'clinically depressed' (L.8), who have been 'treated for depression' (L.9), who are 'retarded' and 'very seriously depressed' (L.10) and who are 'on antidepressants' (L.11). The contextualisation of the client's case against the Hope House scenario serves to heighten the sense of his vulnerability. It would be heard by the team as part of an ongoing sequence of events at Hope House. Following Heritage, members would interpret CPNC's 'conversational contribution' as a veiled plea for help against the machinations of the Resettlement Officers who 'snatch' (L.13) vulnerable clients (1984:242).

CPNC's utterance on Ls.32-33 ('I just wonder if other people have that experience with the direct access hostels') — constitutes further grounds for discussing the case. It also ties back to Ls.6 and 7. It demonstrates the enactment of teamwork. The case fits MHT concerns as its subject is mental illness. It is also an exemplary case as it invites the team to debate its shared experience.

Occasionally, cases are constructed around *physical* ill health as the following extract shows:

Extract 3:6

→ 3 M: Um [pause] — has anybody got any ideas about housing for somebody that I, uh, have
4   been seeing? His name is Fred Turner and he's, um, fifty three years old and he's — at the
5   moment he's in Queen Margaret's Hospital in Corrington with ten per cent burns. Um —
6   he's been in about a month. He was doing quite well up till about two weeks ago when he
7   stopped eating and drinking so he's become very weak and is being fed through a tube up

8	his nose and [he's] also become incontinent so he's got a bag as well so he's not, um, in
9	any condition to have anyone come and do an assessment in Community Care, um —
10	though Ben and I referred him to Ashvale Social Services

This case is presented on similar grounds to that of Extract 3:4. The client is described as ill, albeit as physically ill in this instance — L.5: 'he's in Queen Margaret's Hospital in Corrington with ten per cent burns'. M, the team's social worker, raises the client's case in terms of his need for housing (L.3). That she wants 'ideas about housing' from the rest of the team constitutes the reason for bringing the case to team attention.

The next three extracts have a slightly different format in that they do not specify that the client is mentally ill. However, in common with the earlier cases, they too provide learning opportunities for the team.

In the first extract there is a shift from 'I want to discuss' to 'I'd like to share information with'.

Extract 3:7

➔ 4	G:	Well — a very quick mention of somebody I'd like to share information with. It's a chap
5		called Tony who's, uh, twenty — nine year old man still living in Hollyview. I picked him
6		up there in July of this year. Ah — main reason for referral was that he was very very pre-
7		occupied with religious tapes and that he thought there was some sort of 'gangland'
8		people after him

The *possibility* of mental illness (in the form of delusions and paranoia) is given as the rationale for presenting the client. His current residence, Hollyview Hostel, is known to the team.

It is OT, the team's occupational therapist who presents the case in the next fragment of data:

Extract 3:8

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  8  OT:    Shall I start then? Okay. This gentleman Mr Dunton who was referred to me by J from
  9         the Downtown Team, um, he came for help with housing. He was referred to her, um —
→ 10        the reason for referral was to assess his, uh, daily living skills
```

OT accounts for the referral in terms of the client's need for an assessment of his 'daily living skills' (L.10). This would be 'heard' as a valid reason for accepting the case in terms of the occupational therapist's particular professional expertise. It also falls legitimately into the team's overall remit to monitor (as well as assess) the needs of single homeless people with mental health problems. It would appear that cases are presented for their interest value or because they exemplify a particular issue or point of practice which impinges on the team's work.

Occasionally, cases involving the use of illicit drugs come to team attention. Clients categorised as primary drug users do not ordinarily fall within the MHT's sphere of professional expertise (cf. Loseke 1989:178). When they do, they are presented as extraordinary cases necessitating a different rationale for presentation by the narrator. In the extract which follows, CPNC presents the case of a female client who is known to use illicit drugs. This represents a different sort of case as the client is not mentally ill:

Extract 3:9

```
  3  CPNC:  This woman — this woman called, um Kim Pontin — who is, uh, thirty four years old and
  4         currently, has had a termination of pregnancy. I really want to discuss — not that she's
  5         particularly, um [    ] or difficult — but I think because it really presents some questions
  6         about, uh, us working with people who present these sorts of problems and, uh
```

The question of the client's mental health status is not invoked in this case opening. Neither is the subject of her using illicit drugs which is not raised till L.26 (not shown) when CPNC reports that she asked the client's hostel worker 'Is she a drug user?' The inference that this might be so is constructed through descriptions of the client's

behaviour which would be heard as suggestive of drug use. CPNC delicately refers to this possibility as 'these sorts of problems' (L.6) in her opening characterisation of the client and raises the question of ethical difficulty as the rationale for bringing the case to the team's attention. It is an exemplary case because it constitutes an ethical dilemma for the team. The case fits MHT concerns about future procedure should such a dilemma occur again.

In summary, MHT casework is a cultural resource for community mental health practice. How cases are opened testify to the teller's competence in appropriately selecting vulnerable clients. Extracts 3:4 to 3:6 demonstrate how members utilise client vulnerability to construct the grounds for making the case. Extracts 3:7 to 3:9 demonstrate how cases fit MHT concerns. All cases represent learning opportunities for members of the team.

Following Atkinson (1995) I contend that MHT casework constitutes a cultural resource in the field of mental health and single homelessness. MHT client descriptions which constitute this resource are situated descriptions. They are also typifications or ideal types of the *sort* of person with which the team deals. Holstein, following Schutz (1970), refers to these typifications as:

'organizationally grounded categories' (1992:27).

Holstein develops this observation suggesting that 'human service professionals' actively create their worlds of work (1992:36). In the MHT setting, members produce organizationally known 'types' which:

'loosely correspond to typical organizational experiences and the various services that an organization might offer' (1992:37).

How the team does such work is the subject of the next section.

3.2 Typicality

Human service work is an interpretive activity (Holstein 1992). Mental Health Team caseworkers construct narratives of the lived experience of single, mentally ill people to account for the team's practical activity in selecting homeless clients for housing. Caseworkers offer these accounts to co-workers as a means of protecting the integrity of their decisions (cf. Loseke 1989). The sense of these descriptions relies on a knowledgeable audience which is able to interpret the tacit assumptions inherent in the talk.[2] The accounts are used to 'manage' practical action by team members in the context of community mental health casework. Such client descriptions constitute the team members' organizational record at the Centre which legitimises their selection decisions and which reproduces the team's collective meaning of single, homeless, mentally ill person (cf. Loseke 1989; also Barrett 1996:88).[3] But *how* do caseworkers account for their selection of clients?

The context of mental illness can be a crucial element in the introduction to the case account as it underpins the practice of MHT casework. Claims are made about the client's mental health status and these claims are initially debated in the clinical frame (Goffman 1974; Tannen and Wallat 1987; Peräkylä 1989). Strong (1979) suggests that a frame of any situation furnishes identities for the participants concerned — different duties being inherent in each frame. Frames are used fluidly by team members to characterise clients and to organise practical action. The invocation of the clinical frame at an early stage in the case account provides the grounds for seeing and 'hearing' the client as vulnerable. In McHugh's (1970) terms this serves to establish client status as pre-theoretic so legitimising client selection. To discuss the appearance, behaviour, speech, family histories and perceived needs of clients is an expectation of mental health casework. The MHT owes its very existence to the success of its claims -making on behalf of single, homeless, mentally ill people.

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[2] Pfohl states that the teams he is studying use material in the past record 'to make theoretical inferences about the patient in the present'. The theorizing which emerges is legitimated by fitting the patient into 'a stock of typified clinical knowledge about persons who have similar characteristics' (1978:129).
[3] Barrett calls the case record 'a testament to consensus' (1996:88).

Clients placed in hostels and accommodated in local authority housing bear testimony to the claims-making skills of the team.

Three case extracts from the Centre demonstrate how MHT caseworkers describe the problem of homelessness as a 'situationally relevant' characteristic of some mentally ill people (Holstein 1992). The case descriptions presented are those which have been referred to the team by hostel staff, other mental health caseworkers or social service agencies. As such, they typify problems that the MHT encounters in its daily work (Holstein 1992). The first of these 'problems' constitutes the type of client whose housing choices are constrained by mental illness:

Extract 3:10

```
13 CPNC:  are depressed — and, um, have been sort of [slight laugh] — [pause] — 'snatched' by the
14         Resettlement Officers and sent down to the South Coast quite quickly when they're not in
15         a sort of 'position' to sort of [     ] — go to the South Coast, and if you are terribly low I
16         suppose you'd go, and both times with disastrous consequences in that they, you know, just
17         become more and more depressed and haven't got their medication and haven't been
18         keeping to, uh, local services, and ended up coming back again because the homes couldn't
19         cope with them. And this has happened again with a man who is — is — who has got sort
20         of, a major depressive illness, and for the first time they've actually discussed with me
21         whether I think this is a good idea for him to go, and I've said 'no'. But the client
```

The 'situationally relevant' characteristic described in Extract 3:10 is the insecurity of client accommodation. CPNC invokes the typical consequences of placement moves on depressed clients (Ls.16-19). Such consequences are familiar to the team: 'And this has happened again' (L.19). CPNC's formulation provides for the team response in similar cases: 'they've actually discussed with me whether I think this is a good idea for him to go, and I've said 'no' (Ls.20-21).

The 'situationally relevant' characteristic described in Extract 3:11 is the lack of daily living skills in a newly placed client:

Extract 3:11

```
8   OT:    Shall I start then? Okay. This gentleman Mr Dunton who was referred to me by J from
9          the Downtown Team, um, he came for help with housing. He was referred to her, um —
10         the reason for referral was to assess his, uh, daily living skills — he didn't have these
11         skills particularly
```

OT accounts for team involvement with the client in terms of assessing his daily living skills (L.10). OT's formulation constitutes the type of client whose placement in independent housing is potentially vulnerable due to a skills deficit. Through this formulation OT is able to demonstrate the need for team involvement. The client's mental health status is not described directly in OT's account. However, his referral from another community team known to the MHT (Ls.8-9) suggests that mental ill health is contextual to the case.

In the last of these 'situationally relevant' extracts, the client's behaviour is described as problematic:

Extract 3:12

```
3   CPN2:  This is - uh - Mr R Stockley — uh — they've [the hostel staff] had a few problems
4          with him at the moment. The reason I want him discussed is because — uh — that he's on
5          his final warning at Scotsway basically, and I think — do some more, or whatever.
6          Basically — what age is Ray? He's a fifty year old man. He's been homeless — on the
7          homeless circuit for about six years — since his mother died. Uh — she was staying in a
8          warden controlled flat, or whatever, so he couldn't actually stay there after she died. But
```

The hostel staff are reported to be having 'a few problems' with the client (L.3). The upshot of this situation is that the client has received 'his final warning' (L.5). CPN2 describes the client's previous history as one of homelessness since the death of his mother (L.7). Her description of him as having been 'on the homeless circuit' (Ls.6-7) implies protracted difficulty in client placement. This description serves to upgrade the urgency of the client's present situation and demonstrates the need for team involvement. Like the client in the previous extract, *this* client's mental health status is not directly described. However, his reported difficulty in maintaining a hostel place (Ls.6-7) implies behaviour which is typically associated with mental illness.

In a sense, all three cases typify the vulnerability of organisational arrangements for client placement once such placements have been accomplished. Extract 3:10 describes the 'threat' from other agencies when clients are particularly vulnerable. Extract 3:11 describes the potential threat of placement breakdown when the client is ill prepared for independent living. Extract 3:12 describes the threat to hostel placement posed by client behaviour. All the extracts demonstrate the continuing need for team involvement. The clients described are typical of the 'type' of client who necessitates team involvement both before and *after* placement has been accomplished.

Following Holstein (1992), the descriptions in each of these cases represent the chosen actions of the MHT caseworkers. As such they have practical consequences in the context of mental health casework which is interactionally accomplished. Holstein refers to such interaction as 'human service rhetoric' (1992:26) where clients can be described as being somehow typical of the category known as 'single, homeless, mentally ill' so that a specific professional response is legitimated. In a sense such descriptions also do the work of differentiating single, mentally ill homelessness from 'ordinary' homelessness which might or might not include mental illness involvement (cf. Loseke 1989). However, when mental illness *cannot* be inferred, the appropriateness of the client is strongly contested, as in the extract which follows:

Extract 3:13

```
100 CPNC:  Yeah [pause]. Or even to support her on some level, but I can't get involved with. This is
101         what/the problem which she had earlier with oral substances. This is not, this is not
102         appropriate for me to get [involved]

103 G:      I mean — would she be amenable to [name of service] as a back up as well — as part of
104         the team?

105 CPNC:  No — that's what the counsellor at, um, the Abstinence Hospital keeps
106         saying, that she — what she's doing is she keeps referring her to different places as she
107         moves on and then, you know — three months later — she's moved again. And she's
108         done this two or three times and she just thinks [      ] there's no point in them just keep —
109         and if they refer her to services like Latimer Street [     ]
```

The rhetoric invoked in Extract 3:13 differs from that found in the previous three. These invoke a background assumption regarding the client's categorisation through descriptions embedded in the professional referral process:

- 'snatched by the Resettlement Officers' — extract 3:10.
- 'referred to me by J from the Downtown Team' — extract 3:11.
- 'on his final warning at Scotsway' — extract 3:12.

They are also typical of the sorts of clients who are described as requiring continued support by the team.

The drug dependent client in Extract 3:14 has been referred to the team by Latimer Street Hostel but only after she had gone to 'the local hostelry' where her behaviour had presented grounds for questioning the theoreticity of her actions:

Extract 3:14

```
 7  CPNC:  I just wanted to see what people thought about [    ]. She came into Latimer Street Hostel
 8         about two weeks ago and they referred her to me after she had gone — to — the — local
 9         — hostelry and had, um, been drinking with a group of men who happened to be there
10         and taken a glass from the bar and glassed herself in the face with it and had in fact,
11         caused quite serious injury, um, and got quite a deep laceration to her forehead
```

Following Loseke (1989:178) 'the organisational structure' of the MHT categorises the characteristics of this case account as 'inappropriate' as the client is deemed as having a primary problem of chemical dependency rather than mental illness:

Extract 3:15

```
164  CPNC:  The outcome — I'm going to see her next week to tell her that I can't be appropriately
165         involved with her — and ask her if she'll — tell the hostel, or give me permission to tell
166         the hostel [    ] and, uh, if she won't, then I'll have to tell her I can't be bothered with
167         when she's unreasonable
```

I will now summarise my findings on typicality. Team use of the clinical frame at an early stage in the case account defines the client as pre-theoretic. Such a definition is situationally relevant to the 'problem' of homelessness. Members construct accounts which typify their daily working practice. Such typifications legitimate the team's professional response to client homelessness. Homelessness is interactionally accomplished through members' practices.

The next chapter deals with closing the case. Closing is an interactional accomplishment of the MHT setting. Members employ a range of closing procedures to accomplish closing. Such procedures draw on the case opening as an interactional resource for the team's local production of case accounting.

Chapter Four: Constructing the Case II

Garfinkel (1992) sees accounts as arrangements of steps leading to the solution of particular local problems in the talk (1992:267). For Garfinkel, members place a high priority on clarifying the various elements which constitute a definition of a situation. Schegloff and Sacks (1974) add that such accounts have to be seen as 'orderly' — methodically produced by community members for one another. The 'status' of accounts derives from their function which enables participants to display to each other 'their analysis, appreciation and use of that orderliness' (1974:234).[1] According to Silverman and Jones (1976), the community is the final arbiter of the validity of any account — the test of the account being whether or not it produces 'demonstrably plausible inferences' (1976:152).

'Endings' or 'closings' are interactionally accomplished. In this sense, they are practical solutions to certain problems of conversational organization (Schegloff and Sacks 1974). They are also one element of the overall structural organization of the account. Dealing with them requires reference to the whole (1974:235). Silverman (1975) explores the 'problem' of 'endings' and suggests that the analytic issue is to reveal the *range* of closing procedures which participants employ in order to produce 'sensible accounts' (1975:288).

In the context of single homelessness how do caseworkers produce sensible accounts? Case closure is accomplished via consensus. Cases cannot end with disagreement, yet closing is not pre-ordained. It builds upon and embellishes the opening rationale. In a sense, it 'recycles' the opening statement. Client descriptions in case openings constitute a resource for team discussion. Drawing on this resource, members display the good sense of what they are doing as new issues emerge in the talk. How members use case openings as a resource is demonstrated in Extracts 4:1 and 4:3.

---

[1] As here, Byrd (1981) also analyses the 'orderliness' of accounts in her psychiatric outpatient study. Byrd suggests that as social agency clients are often defined as being unable to 'negotiate the terms of their treatment contracts' - staff members compile case folders to 'demonstrate(s) the honoring of client claims to just treatment' (1981:17). Pfohl (1978) also alludes to accounts as records of clinical expertise with a legalistic purpose. In Pfohl's study, psychiatric professionals were actually reporting to a legal audience (1978:96). Chapter Six, p.150 and Chapter Seven, p.180 discuss the case record in MHT practice.

4.1 <u>Closing the case</u>

In Extract 4:1, G describes the client as being the ongoing responsibility of another team (Ls.5-6 and L.8). This opening description constitutes a resource which enables team debate on the principle of *not* engaging with non-catchment area clients (Ls.11-12). This is seen later in Extract 4:2 when the client description is used for closing the case.

Extract 4:1

```
 4  G:   Can I also very quickly mention someone that I might need some kind of support with
 5       really — is — a — basically — a lady was referred by [pause] West Greenton CPN
 6       Service down in Moreton; there's a kind of Community Mental Health Team there. And
 7       this particular CPN 'phoned me up at the beginning of the year about a woman, thirty years
 8       old, who is well known to the Service, but for some reason, her housing broke down and
 9       she's now in bed and breakfast

10  R:   Oh — I know

➜ 11  G:   And he sort of, more or less, just said that because she's now in bed and breakfast, our
➜ 12       team should deal with it — and I sort of — put him right, you know. I think, that's not on,
13       really, but if you want my help in looking at some other options [     ] and so we left that,
14       um — then Y — Y took a call a couple of days ago from another CPN — from the same
15       Mental Health Service saying that this lady, uh, I think — also referred her to HU [a
16       colleague]
```

Pre-closing refers back to the case opening. This is demonstrated in Extract 4:2. Y's formulation of the principle (L.34) builds on those parts of the opening description which construct the client as the responsibility of another team. G's utterance on Ls.37-38 ('she's known to the Service') is the upshot of Y's utterance on L.34 which formulates the principle. Y's pre-closing invitation on Ls.39-40 ('we've done a housing assessment. And I said: I can't say I'm worried about her') — is the upshot of G's utterance (Ls.37-38) which describes the client as being the responsibility of another team:

Extract 4:2

```
31  Y:   Basically, what he said to me on the 'phone [     ] at the time — I didn't know she'd
32       already been referred in January, and she'd only been waiting around nine months. But, the
```

33		issue *really* was/is, well, that um — he was saying: Ah [ ] keeps referring people to us
→ 34		you know, and we can't really deal with all their referrals. I think he was actually hop-
35		ing we would take her on. That's a whole area of work that we'd

36	G:	The impression when he first rang me was that — it's actually that they're dealing with
37		her type of thing — mental sort of health, perspective — in that she's — she's known to
38		the Service. But because she was in a bed and breakfast, it would take longer to

| 39 | Y: | Well, he said to me: I don't know why they've referred her to us; we've done a housing |
| 40 | | assessment. And I said: I can't say I'm worried about her |

| 41 | | [LOUD LAUGHTER] |

Y's pre-closing invitation (Ls.39-40) ties in with the case opening (Extract 4:1, Ls.5-6). It delineates the boundaries of the MHT's work on behalf of the client (Ls.39-40). The principle is constructed through a case account which enacts the team's 'line' on inappropriate referrals. The upshot of Y's pre-closing invitation is an episode of team laughter (L.41). This marks members' affiliation (cf. Rostila 1992).

Like Extract 4:1, the extract which follows also demonstrates how case openings constitute a resource for team debate. In this extract, DR describes the client as being mentally ill (L.8) and potentially dangerous:

Extract 4:3

| 4 | G: | You know — I was thinking of the other guy that you mentioned you've been seeing |

5	DR:	Yeah — I was going to raise him because I'm going to see him with [doctor's name] with
6		a view of sectioning[2] him later this afternoon. Just on the off-chance that he disappears
7		from Oakley House and just turns up. His name is [name of client] — an Hungarian guy
→ 8		— um — very very psychotic — um — very thought disordered, full of a lot of delusions
9		about people injecting him with PC's, um. Thinks that the staff in Oakley House know
10		about it. Doesn't yet think that they're actually doing it to him, but he's convinced that
11		everybody else *knows* what's happening. And so — he gets very irritated with people. He
12		was chucked out of Bellmonts Hostel three times, ah, the last time because he was found to
→ 13		have a hatchet, um

| → 14 | CPN2: | He was actually threatening to use it |

| 15 | DR: | Right, so — again — if this gent turns up anywhere, he would be best seen with somebody |
| 16 | | else, but I hope we're going to be able to get him in [to hospital] |

| 17 | | [GENERAL BACKGROUND MURMURING AMONGST ALL TEAM MEMBERS] |

[2] This refers to the Mental Health Act 1983.

18   [Tape, over: off tape remark made that the client would be best seen 'in a full set of armour'
19   — a remark that was greeted by laughter from all]

20 CPN2:   About this business with the hatchet

The client's dangerousness is inferred. The doctor is going to see the client 'with a view of sectioning him' (Ls.5-6). He is reported to be 'very, very psychotic,' 'very thought disordered', 'full of a lot of delusions' (L.8). The client gets 'very irritated with people' (L.11). He has been 'chucked out' of his hostel three times' (L.12). On the last occasion this happened 'he was found to have a hatchet' (Ls.12-13). At no point in this opening account is the client actually described as dangerous. However, the various descriptors used (speech content and behaviour) are indexically linked to the doctor's diagnosis of psychosis (L.8). That this psychotic client is also in possession of a hatchet (L.13) sets up the future possibility of danger. CPN2's utterance: 'He was actually threatening to use it' (L.14) endorses the possibility of danger.

The client's unpredictability is a cause of concern to the team when this new information emerges about a hatchet. The dilemma for the team is whether or not they alert *other* care teams to this information so compromising client confidentiality (Extract 4:4 below). It is an exemplary case as it uses resources in L.22 for Ls.57-58 which constitute pre-closing. L.22 represents the team's dilemma. It also acts as a resource which permits debate about the principle:

Extract 4:4

20 CPN2:   About this business with the hatchet

21 G: I suppose — going back a bit to [name of client's] case. I mean — say, for example,
➜ 22   should we see someone like that — should we alert other teams?

23 CPN2:   Well — I knew that/I rang around places — Bellmonts Hostel, and um [   ]. At his last
24   admission, he got chucked out of Bellmonts Hostel twice and was allowed back the third
25   time on the proviso that he would see the Mental Health Team. And I rang [Hostel staff
26   member] and she immediately said: Very dangerous man; be very careful. Never see him
27   alone

28 Y: The other thing on that issue I think is if it's somebody we've seen very recently and we
29   really think is a risk, then I think that's fine. But I think the thing about [client's name] is
30   different, is that he hasn't been seen for about nine months

31 G: You haven't seen [   ] — he was alerted

32 Y: Yes — he was out quite a long time. I mean this guy — this guy's actively [disturbed]

33 G: No, I just mean, as a matter of formality — of routine — should we be [pause] — linking
34   with the other three teams? You know — if you see somebody like him/we pick up, and
35   then, if he disappears, should we let the other three teams know as a matter of routine or
36   not?

37 CPN2: That's — very time consuming

38 R: And I think — and I don't think we should make any strict rules about 'routine' on things
39   like that. These things need to be dealt with on an individual basis — a lot — I mean —
40   there need to be basic rules, basic policies about the way we deal with confidentiality. But
41   in circumstances like that, you're looking at — you need to think like, you know: Is he
42   *known* to have been seen in other areas? Does he/is there any history of him using any
43   other centres and, if so — is he likely to go — or, if so, is he likely to go — is he likely to
44   come to the attention — I mean, if he brains someone with an axe — chances are, he's
45   going to come to somebody's attention

46   [GENERAL LAUGHTER]

47 CPN2: If there's an axe — yeah

48 R: About how *much* you give people as well, 'cos if you ring a team and say: There's this
49   guy, name of — name is Y — um — and this is his date of birth — that's quite different.
50   And if you come into contact with this man — we suggest that you contact us *again*

51 DR: Yeah

52 R: That's quite different from fr — saying: Well, this guy is — you know — here's his
53   personal history, here's the family history, here's what — here's all this — when they may
54   not come into contact with him at all. So the 'alert' is on the basis of a name, and you're
55   not giving them any/you're not breaching any massive confidentiality by giving some-
56   body a name [pause] are you? And saying: You need to be aware of this man but

➔ 57 DR: But it's sticking to the principle that information goes where there's a need to know, and
➔ 58   it's the same thing and that's [pause]

59 G: Well, I mean — I was just thinking that in this case — it did happen, the DHT[3] did ring
60   us up, you know — as a routine; they did ring us. We've been dealing with him for —
61   what — about three weeks now and it's only recently we got this information about the
62   hatchet

63 CPN2: Yeah

[3] District Health Team.

72

DR's utterance on Ls.57-58 constitutes the principle and is heard as a pre-closing invitation. It ties back to G's utterance on Ls.21-22 which represents a formulation of the team's dilemma. However, in a sense, pre-closing builds on talk which occurs even earlier in the account. It uses that element of the client description given in the opening which describes the client as being in possession of a hatchet:

Extract 4:5   (Part of Extract 4:3)

12 DR: was chucked out of Bellmonts Hostel three times, ah, the last time because he was found to
13   have a hatchet, um

The MHT routinely works with psychotic clients.[4] What makes this case *different* is the additional inference that the client is dangerous and that he is in possession of a hatchet. Whether or not the team can operate within its 'absolute' rule on client confidentiality in such circumstances becomes the object of debate.

The doctor's utterance on Ls.57-58 (Extract 4:4) constitutes the principle and is heard as a pre-closing invitation by returning to why the case is exemplary. He takes up the turn which R provides on Ls.52-56. R proposes a formulation of the dilemma which alerts other agencies to the presence of possible danger but which safeguards client confidentiality.

4.2 Summary

Data drawn from a range of MHT transcripts suggests that the fundamental beliefs and values of the 'world' of mental health care are ritually enacted and collaboratively organised at the weekly case conference (cf. Anspach 1988). Although case accounts vary according to length and content — pre-closing generally constitutes the principle which underpins the case. This builds on the case opening. It stands as a 'part' to the 'whole' and represents a microcosm of the culture in which mental health practice is

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[4] This is in contrast to Byrd's (1981) study where clients diagnosed as psychotic are considered 'inappropriate to available therapies' (1981:79). 'Exclusion criteria' in Byrd's research are clinical. 'Inclusion criteria' are personalistic eg. intelligence (Byrd 1981:109). Exclusion criteria in the MHT research are geographical and administrative (see 6.4).

embedded. It is both 'socially constituted' and 'constituting' having been 'talked into being' by the members themselves. The object of this collaborative venture is the working practice of the team — their 'rationale' for care. This 'rationale' identifies (and celebrates) their specific expertise and competence and constructs the boundaries in which they do their work. The issues which have to be 'managed' in daily practice are not only issues of care for the client but are also issues of 'principle' for MHT teamwork.

4.3 Closing in detail

I will now examine closing invitations in more depth. As my work is case study research rather than conversation analytic, I will not be focusing on the fine detail of closing invitations. Rather, I propose to examine how members make sense of their decisions by displaying that they have said enough about any one case.

Two case extracts from the Centre demonstrate how caseworkers utilise closing invitations to end the case. In the first of these extracts (Extract 4:6 below), Y, the team's housing officer, is reporting a conversation she had with Tony — a hospital consultant with whom the team liases. Her utterance on L.40 is a pre-closing invitation. The team's knowledge of Tony is indexically linked to Y's pre-closing invitation. Following two episodes of team laughter (Ls.41 and 44) — Tony is reinvoked by G on Ls.50-51:

Extract 4:6

39 Y: Well, he said to me: I don't know why they've referred her to us; we've done a housing
→ 40   assessment. And I said: I can't say I'm worried about her

41   [LOUD LAUGHTER]

42   right — you know [   ] — let's be optimistic, you know. Let's keep the possibility that
43   they're concerned about her mental state and they think she needs assessing

44   [GENERAL LAUGHTER]

45	G:	I suppose my worry is, as I said to Y, my immediate concern is that she'll probably get
46		pushed onto HU [a colleague], who falls in between the two teams. I suppose the other
47		thing is really I'm, I'm — the first time round [ ] it might well be that she's known to
48		them and is a bit difficult. She's been in bed and breakfast for nine months now

| 49 | | [VERY LONG PAUSE] |

| 50 | G: | [remark addressed to Doctor] I thought I'd let you know because it's possible that you'll be |
| 51 | | chatting to Tony at some stage [laughing] |

| 52 | DR: | That's right |

| 53 | G: | And Tony, you know — has these high — high aspirations for the Team [laughing] |

➔ 54 DR: Sounds to me like an attempt to make a helpful comment from a great distance

| 55 | ALL: | Yes |

| 56 | Y: | From a great height |

| 57 | DR: | Okay |

DR's utterance on L.52 functions as a validation of the team's account. It validates the account as properly rule-governed. It makes 'organizationally demonstrable sense' (Garfinkel 1992:11). The remainder of the account has features of a proverb or maxim which typically produces agreement in the hearer (cf. Silverman 1998a). The upshot of DR's utterance on L.54 is agreement from all team members (L.55). In keeping with the notion of proverbs, DR's utterance is unchallengeable. It functions as a device to set up case closure. Consensus is reached with the doctor's 'Okay' on L.57 — and case closure is accomplished. Summary statements of what members have said before, and the upshot of these statements for the future — are utilised as a way of getting out of the topic.

In the second extract (Extract 4:7 over page), the team debates the principle of maintaining client confidentiality when there is a known history of violence. Breaking strict confidentiality is constituted as a practical necessity from the point of view of staff safety in exceptional circumstances. However, routinizing this breach of client trust is strongly contested (cf. Extract 4:4, Ls.38-39). In Extract 4:7, G's utterance on Ls.131-132 demonstrates pre-closing by starting to make the case exemplary:

Extract 4:7

→ 131 G: Sounds like something we need to discuss in private sort of moments [pause]. There are
→ 132   many many

133 R: It *is* something we should talk about

134 CPNC: Yeah— we *have* talked, and I suppose that you [name of staff member] produced consent
135   forms formalizing our agreement

136 J: But I think, as a team, it's good that we discuss issues as they come up

137 DR: Sure — yeah

138 CPNC: Yeah

→ 139 DR: Okay. So we'll wait until he's actually

→ 140 CPNC: Until he's on our doorsteps

→ 141 R: He's imprinted onto our brains now

142   [GENERAL LAUGHTER]

143 CPNC: Yeah

L.131 implies why the case is exemplary. It constitutes a pre-closing invitation identifying the need to discuss the principle of client confidentiality — but not at this particular moment. The turn made available by G is taken up by R (L.133) who supports the proposal. CPNC takes the turn made available by R. Her summary on Ls.134-135 constitutes pre-closing. The upshot of this is J's formulation of the principle on L.136. L.136 is an implicit maxim ie. we should not let things pile up/we should talk about them all the time. DR takes the next turn. His utterance on L.137 supports the principle. The upshot of DR's support of the principle is CPNC's utterance on L.138 which further endorses the principle. DR takes the next available turn (L.139) which is a continuation of his previous utterance on L.137. Like Extract 4:6, L.54 — Ls.139-141 of Extract 4:7 have the features of a maxim which is constituted through three speakers. CPNC takes up the maxim on L.140 and R completes it on L.141. Case closure now becomes imminent. An episode of team laughter is the upshot of this collaborative process of case closure set up by DR on L.139 (cf. Extract 4:2, L.41). Closure is accomplished by CPNC's 'Yeah' on L.143 and the case ends.

Sometimes, off topic work is done by the MHT to enable closing — as I will show later (see pages 79-80). Such work functions to create a space for a team demonstration of its particular speciality and competence. This team demonstration can function to enable closing following the *delay* produced by such work.

In the next extract, laughter signals a demonstration of team skill (L.69). It also marks coming out of a serious discussion:

Extract 4:8

63 CPN2: Yeah

64 G: So he could have a mince up while we're dealing with him

65 Y: But he already had a knife at Oakley House didn't he? They were already concerned

66 CPN2: But that's because he is a Vegan, and he chops up his own vegetables

67 G: He was just trying to play that down wasn't he?

68 DR: Oh, right

➔ 69   [GENERAL LAUGHTER]

70 Y: But no — but you'd already expressed a concern about, about

71 CPN2: Well, yeah — ah — their main concern originally was that he was following women
72   about at night — and he's a big guy — very close to them, and staring at them. And they
73   were quite concerned about him, especially over weekends because they've only got
74   volunteers working over the weekend. They don't have any Project Workers. The Project
75   Workers are at the other end of the 'phone — um — so yeah, we calmed them down about
76   that. But he's [   ] — he's been escaping through the net as far as I can gather for quite a
77   while

78 G: Uh, huh

79   [LONG PAUSE]

The episode of team laughter on L.69 downgrades the preceding interactive sequence (Ls.64-68) in which team members collaboratively demonstrate the implausibility of the client possessing a knife because of being a Vegan who 'chops up his own vegetables' (L.66). In this sense, the laughter serves as a marker — delineating the

implausible and plausible aspects of the client's possible motivation in keeping a knife. Laughter fulfils many different functions in MHT casework. It can have a 'signalling' purpose — as described earlier. It can denote team affiliation (Rostila 1992). It can mark rule-breaking rather than 'attacking the moral character of the rule breaker' (Dingwall and Murray 1983:135). It can 'distance' competing professionals for client care. It can also signal a demonstration of team skill, which it appears to do in the preceding extract. In all these senses, laughter is functional to team work. It is also functional to getting off the topic which is therefore functional to the case.

Y takes the next available turn following the episode of team laughter. She re-invokes the notion of client dangerousness with her appeal to 'concern' (Extract 4:8, L.70). The upshot of Y's utterance is that CPN2 is presented with the opportunity to:

- elaborate on the concern about a dangerous client

  ('he was following women about at night' — Ls.71-72)
- demonstrate caring professionalism

  ('they've only got volunteers working over the weekend' — Ls.73-74)
- constitute the MHT as experts

  ('we calmed them down about that' — Ls.75-76)
- endorse the practical reality

  ('he's been escaping though the net as far as I can gather for quite a while' — Ls.76-77).

G's utterance 'Uh, huh' (L.78) constitutes consensus. It is contingent upon the practical reality encapsulated by CPN2's utterance on Ls.76-77. What initially began as a debate around access to information and client confidentiality eventually becomes a validation of members' work incorporating a new principle. Ls.71-77 represent a display of team competence which validates the new principle. In a sense, it accounts for, and is an account of, the new principle that information pertaining to a violent

client can legitimately be given to other professionals on a 'need to know' basis. Case closure is possible once the principle is endorsed.

Extract 4:9 also demonstrates how off topic formulation is utilised as a pre-closing device. The device is used to extend the team rule on confidentiality in the context of client dangerousness. I propose to work *backwards* through Extract 4:9 to examine how team members make sense of their decisions:

Extract 4:9

→ 112 R: it's an issue around confidentiality

113 DR: I must admit, I'm not really convinced [   ]

114   [LAUGHTER]

115 J: What about when you think somebody's heading for a section — when you think they're
116   sectionable? 'Cos that happened to me a little while back at [name of home] — and I
117   knew she'd been in touch with St. Hilda's recently, and I did try and talk to her about
118   notes but she just wasn't in touch with anything I was saying *at all*

119 R: I think there are circ — I mean, my view is that there are circumstances, you know,
120   where you can't get consent because, you know, somebody's mental state is — and you
121   actually need that information at that particular time

122 J: Yeah

123 R: I think that's reasonable, um — yeah — in that particular circumstance — you can't get
124   consent from them and you're thinking about sectioning them anyway. I mean, of course
125   the detail of the section will be done on the basis of what she's presenting with then —
126   so, whether or not there's a psychiatric history shouldn't, um — influence that. But yeah, I
127   see what you mean

128 DR: I wouldn't have any objections under those circumstances. I — it's more as a routine,
129   kind of thing

130 CPN2: Yeah

CPN2's utterance on L.130: 'Yeah' — is the upshot of DR's formulation of the principle (Ls.128-129). DR's formulation of the principle demonstrates 'doing consensus'. He takes the turn made available by R whose utterance on Ls.123-127 is

a pre-closing device. It constitutes the grounds for reasonable procedure in the context of client confidentiality. R's formulation represents a continuation of his previous utterance which begins on L.119. From L.119-121, R outlines principles relating to team practice. These construct the context in which team action is constituted as valid. The contextual circumstances invoked are grounded on the difficulty of obtaining consent because of the client's 'mental state' (L.120) — and on practical expediency.

R's utterance on Ls.119-121 is contingent upon J's preceding turn which is an off topic formulation of a hypothetical situation (Ls.115-118). It is constructed through the invocation of a known (but nameless) female client from the past.

The function of J's off topic talk in Extract 4:9, Ls.115-118 is 'facilitatory' in that it allows for the next turn to be taken up by R (L.119). R shifts the debate from 'past hypothetical' to present 'practical'. Like Extract 4:8, it serves to widen debate on the principle of confidentiality. J's uptake (L.115) is contingent upon an episode of team laughter (L.114). This appears to signal the closing of the debate. The episode of laughter is the upshot of DR's utterance on L.113 which is 'heard' as an invitation to discuss the principle. The turn taken by DR is the upshot of R's definition of the principle on L.112.

A similar device is reported by Pfohl (1978) in his Lima State Hospital study. Pfohl refers to this as 'derailing the topic' (1978:185). Its function in Pfohl's study appears to be one of deflecting conflict. The conflict he describes is that of disagreement between the Psychiatrist and the Psychologist. Reconciliation occurs through the use of a 'more encompassing theory' which preserves 'the oneness of diagnostic expertise' (1978:187).

In all MHT accounts, teamwork has to be adequately demonstrated before a case can close. Extract 4:10 which follows, demonstrates correct procedure in the context of clients who are likely to abscond — and hence, constitutes closing. The extract is

drawn from the case of a male hostel resident who is reported to be preoccupied with religious tapes. The client in question is a resident of Hollyview Hostel. G has maintained loose contact with the client for a number of months as the client is very suspicious and resents intrusion. His mental state has deteriorated since G's previous visit and G is alerting the team to the client's existence in case he absconds and turns up elsewhere. Like Extract 4:9, I will work backwards through this extract to see how members make sense of their decisions:

Extract 4:10

→ 36 G: I mean — I think he probably *will* see me again — if he *does* turn up somewhere else

37 DR: If he turns up somewhere else, would you like us to send him back to you?
38 G: Oh yeah, I think I/the first instance will be for me to see him — but there's nothing there

39   [GENERAL LAUGHTER]

40 CPNC: Right

41 G: I mean, it's not a problem with me; it's more a problem with treatment

42 Y: What's his name again?

43 G: Tony — Tony Andrew Couldon

44 Y: Hmm

Y's utterance on L.44, Extract 4:10 (above) accomplishes case closure. There is no further talk beyond this point. It is the upshot of G's reiteration of the client's name on L.43. G's utterance on L.43 is contingent upon Y's utterance on the previous line: 'What's his name again?' (L.42). Y takes the turn made available by G. What this *leads* to ('not a problem', L.41, Extract 4:11) is what does the closing:

Extract 4:11   (Part of Extract 4:10)

41 G: I mean, it's not a problem with me; it's more a problem with treatment

81

It is the upshot of CPNC's utterance on L.40, Extract 4:10, which is heard as agreement. CPNC's utterance is contingent upon G's pre-closing invitation on L.38, Extract 4:12, below:

Extract 4:12   (Part of Extract 4:10)

38 G: Oh yeah, I think I/the first instance will be for me to see him — but there's nothing there

G takes the turn made available by the doctor's elaboration of the solution on L.37 (Extract 4:10). This elaboration is the upshot of G's proposed solution on L.36 which is heard as pre-closing:

Extract 4:13   (Part of Extract 4:10)

36 G: I mean — I think he probably *will* see me again — if he *does* turn up somewhere else

L.36 is an upshot statement which eventually leads to closing. Extract 4:10 demonstrates how competent teamwork is enacted through procedural rules. In the case of clients who are likely to abscond, managerial accountability remains with the designated team member. An action plan is produced for future contingencies.

In the next extract, competent teamwork is demonstrated through citing the rule of advocacy — so constituting closing. Advocacy is a recurring phenomenon in mental health casework. Advocacy need not be used in closing, but it is, here. This is possibly because the subject of the account is constructed as being so ill that he is reported as not being able to make a judgement about his own welfare. In such a situation, caring professionalism is invoked for a client at risk as mental illness is central to the team's work. CPNC is the main protagonist in the case in which she invites the team to debate the ethics of requiring clients to make decisions about housing when they are mentally ill. The hostel client in question is described as being 'severely depressed'. He has recently been visited by the Resettlement Officer who has asked him to move to the

south coast. In Extract 4:14 (below), team debate reaches a point at which the intervention of the client's GP (Dr L) is deemed to be crucial:

Extract 4:14

191 DR: Has Dr L done [Clomipramine] levels?

192   [PAUSE]

193 CPNC: No — but I don't know whether she was arranging to/for some, I don't know whether she
194   did that. 'Cos he's not been in a fit state to get them done — to have the blood taken

195 DR: No — that's the problem

196 CPNC: 'Cos he's so slowed up isn't he?

197 DR: Sounds as though, uh, we need to keep pressure on Dr L actually to get him [admitted]

198 CPNC: Yes — I'll — did you speak to her yesterday?

199 DR: No, I didn't, but I'll speak to her today

200 CPNC: I'd second that

201 DR: I think he's going to get more and more of an issue — but she's [the doctor] is chock a
202   block

203 CPNC: Yeah — I know — at least — yeah

CPNC's utterance on L.203 (above) constitutes case closure. It is the upshot of the doctor's utterance on Ls.201-202 which is an upshot statement. DR takes the turn made available by CPNC's utterance on L.200 which endorses agreement. He hears it as an invitation to 'do closing'. CPNC's endorsement confirms the DR's previous utterance which constitutes the intention to speak to Dr L (L.199).

DR's utterance is contingent upon CPNC's utterance on L.198 which constitutes agreement. CPNC takes the turn created by the doctor's previous utterance on L.197 which is also an upshot statement, that is, an upshot of what members have been saying on Ls. 191-196. Indirect advocacy through pressure on the client's GP to get

him admitted to hospital has been demonstrated by the team. Team skill has been displayed and the case is accomplished.

The team's case discussions reflect a 'unified professional discourse' (cf. Griffiths 1997:77; also cf. Barrett 1996:11).[5] This utilises both psycho-social and medical model approaches. Closing is accomplished following the team's enactment of its specialism. Generally speaking, the team psychiatrist takes a non-hierarchical role in team decision-making, contributing his medical expertise when present and where appropriate (cf. McClelland and Sands 1993:87; also cf. Barrett 1996:73).[6] TL, the team leader, is the team's manager. He is a CPN. In practice, both are rarely present at the same meeting. Decisions are frequently made in the absence of the team doctor. Like the observations made by McClelland and Sands (1993) on interdisciplinary meetings about developmental disabilities — data from MHT meetings suggests that CPNs attempt to speak for the doctor when he is not present. They also dialogue with the doctor in broadly medical terms when he is present. This is demonstrated in the following extract:

Extract 4:15

357 DR: At some point, did you try to feel her pulse — to see what pulse is there?

358 Y: I wouldn't know [laughing] how to do that

359 DR: You wouldn't

360 Y: I've never felt anyone's pulse

361 CPNC: I'll show you how to do it

362 DR: You show her

➔ 363 CPNC: Are you thinking about thyrotoxicosis?

364 DR: She hasn't got swelling round the neck has she?

365 CPNC: Bulgy eyes?

366 Y: Her eyes don't look

[5] Barrett states that in the Ridgehaven study, there was an 'underlying bedrock of consensus' amongst staff. All agreed on the common goal which was the treatment of mentally ill patients (1996:11).
[6] The professionals in Barrett's study 'consented to participate in a team defined by psychiatric knowledge' (1996:73). They did not submit to control by psychiatrists in an overt way.

367 DR: No. It could — she could be myxo- myxodematous, which is the other way. Her eyes
368   could be — you wouldn't see anything dramatic

In this extract the doctor and CPNC interact with Y (the housing officer) to construct a client diagnosis. CPNC's utterance on L.363 invokes the possibility of thyrotoxicosis. DR takes the turn made available by CPNC's utterance — but addresses his question to Y rather than responding to CPNC's formulation (fieldwork observation). This might be 'read' as an attempt to reclaim his professional territory temporarily taken by CPNC.[7] CPNC takes the next turn adding to DR's previous utterance rather than offering an alternative (L.365). Y responds to CPNC's utterance (L.366). The doctor takes the next available turn reasserting his medical superiority by offering a different diagnostic formulation (L.367 — 'she could be myxo- myxodematous'). However, as stated earlier, he is not always the team member to close the case.

It is rare for a team member *other* than the doctor or a CPN to invite closing or to actually close the case. In the context of mental health casework it is the psychiatrist who is professionally dominant and who has legal accountability for the team overall (cf. Prior 1993:79). This greater accountability is possibly reflected in closing the case. In a sense — it represents a 'seal' on the case account or 'package'. If the doctor is not present, a CPN (usually the Team Leader) will close the case. Like the doctor, CPNs have a 'strong health orientation' (Sheppard 1990:83). This might account for their role in the social organisation of the MHT and its division of labour (cf. Prior 1993:159).

Transcript data suggest that appeals to a range of principles are embedded in casework talk. Extract 4:4 highlights the principle of maintaining client confidentiality. Extract 4:7 debates the ethics of sharing information about clients with other care teams. Extract 4:10 explores managerial accountability in the context of casework. Extract 4:14 displays the rule of advocacy. Other data from fieldwork notes indicate that the MHT 'does'

[7] The doctor uses commonsense language on L.364 (Extract 4:15). This is in contrast to CPNC's use of professional medical language on L.363 which precedes it. Barrett (1996) observes that the use of commonsense language, in a paradoxical way, draws attention to professional expertise. Its 'layness' hints at the speaker's specialised skill (1996:97). In Extract 4:15, DR reclaims his professional territory on L.367.

- legitimating intervention [Tape 3, Case 1]
- the anomalous case [Tape 4, Case 1]
- legal accountability [Tape 4, Case 2]
- differential diagnosis [Tape 12, Case 3].

Equally important throughout is how the principle is discussed.

Another device which can initiate closure is that of off topic formulation (refer to pages 79-80). This appears to have the function of temporarily 'sidelining' preceding talk about the principle thus opening up the case to wider debate before closure is finally accomplished. The next extract demonstrates how this is done.

Extract 4:16 deals with the dangerous client already described in Extracts 4:3-4:5. In Extract 4:16, G does *not* take up the closing invitation made available by DR (Ls.57-58). He moves off the topic of absolute confidentiality and appeals to an earlier case in which the District Health Team approaches the MHT for confidential information. G's utterance (Ls.61-62) represents a warning to team members about the client's possession of a hatchet.[8] This new information sidelines preceding talk about the principle of confidentiality and opens up the case to wider debate. Ls.61-62 constitute an invitation to debate upon the practicalities of working with a disturbed client in possession of a hatchet. Upholding the team's 'rule' about client confidentiality becomes the context of this debate. DR's utterance on L.57 (Extract 4:16) about only relinquishing client details on a 'need to know' basis and not as a routine has similarities with Extract 4:9, Ls.128-129.

Extract 4:16

57 DR: But it's sticking to the principle that information goes where there's a need to know, and
58   it's the same thing and that's [pause]

59 G: Well, I mean — I was just thinking that in this case — it did happen, the DHT did ring

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[8] Byrd (1981:55) states that members' discussions can hinge on an additional piece of evidence which allows 'the re-interpretation of the case'.

60		us up, you know — as a routine; they did ring us. We've been dealing with him for —
61		what — about three weeks now and it's only recently we got this information about the
62		hatchet

63 CPN2: Yeah

64 G: So he could have a mince up while we're dealing with him

65 Y: But he already had a knife at Oakley House didn't he? They were already concerned

66 CPN2: But that's because he is a Vegan, and he chops up his own vegetables

67 G: He was just trying to play that down wasn't he?

4.4 Concluding remarks

Data such as 4:16 demonstrate that telling the case is active work. It is constituted through the practical reasoning and experience of team members. It is demonstrated weekly at the case conference as a collaborative venture at all stages of the discussion of individual cases. It has features of a 'linguistic ritual' (Anspach 1988:357) and provides a cultural resource for MHT practice (Atkinson 1995). It serves as a cultural resource for the production of 'facts'. Working backwards through transcript data provides a schema which describes how case account endings are locally organised in the MHT setting:

Table 4.1: A schema for closing the case

PRE-CLOSING INVITATIONS	⟷	POSSIBLE ELABORATIONS	⟷	CLOSING
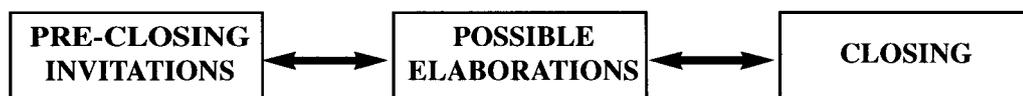
Discussing and closing a case is a dynamic continuum which has the capacity to start up again at any point in the account. Each part of the process is contingent upon the preceding turn. Consensus constitutes 'closure' which is the 'upshot' of team members' collaboration. However, not all endings are accomplished in terms of a particular case — even if the principles are raised earlier in the case. Extract 4:3 for

example provides an illustration of how consensus about the principle is reached early in members' discussion but is reinvoked later in the context of a practical dilemma. The case 'works' here to demonstrate much more than supporting a principle. It also demonstrates its practical application. Context here is locally enacted (Silverman and Gubrium 1994:180).

Having examined how the MHT constructs the case, I will now analyse in more detail how members construct the client. Constituting client vulnerability is fundamental to this process so examining how members do this is where I will begin. Literature used in the next chapter will include Garfinkel's (1992) concept of the indexicality of descriptions and Hammersley and Atkinson's (1989) notion of 'rites of passage' in biographical accounts. Later, it will use McHugh's (1970) concept of the nature of deviancy and Dingwall and Murray's (1983) work on patient categorisation. Discussion on members' practices which construct the client will then be related to Goffman's (1974) concept of frame.

Chapter Five: Constructing the Client I

How members construct the client is a crucial component of casework. MHT case accounts can be seen as 'representing the case' or as being 'representative' of the case. On the one hand, they are partial biographies and might be heard as 'moral tales' in the interactionist sense. They bear many of the characteristics and features routinely located in biographies, life histories and other literary texts. Denzin lists these as:

> *'Opening, closings, linearity, objective voices, objective markers and*
> *turning points . . .'* (1989:34).

On the other hand, they are qualitatively different in that they utilise only those selected features of the client's history which are pertinent to the team's work. It is in this sense that I suggest they are used ie. defining the 'problem' or 'defining the case' which provides the context for the team's collective interpretation. Garfinkel puts this very clearly:

> *'The task of historicizing the person's biography consists of using the*
> *documentary method to select and order past occurrences so as to*
> *furnish the present state of affairs its relevant past and prospects . . .'*
> (1992:95).

It is the social organisation of the MHT accounts rather than the accuracy of their case reporting which is my central concern here (Silverman 1993:61). The accounts are produced by and for a specific audience of health care professionals which makes sense of its own decision-making processes through the 'language' and 'rhetoric' of vulnerability (Silverman 1993:62). The MHT produces and works up a particular description of the client which begins in the opening narrative with the presentation of the case. The account which is eventually produced is a collaborative event which has

many voices but only a single viewpoint. It functions as a cultural resource which has sense and meanings upon which the team may draw.

This chapter will be divided into three sections: the construction of clients as vulnerable, the morality of clients' actions and a summary of morality and theoreticity. The issues of vulnerability, morality and theoreticity are interrelated in the team's construction of the client. The issues will be separated for purposes of clarity. This will involve referring back to some data in different sections.

5.1 Clients as vulnerable

I have already suggested that caseworker 'stories' utilise 'vulnerability' as an essential 'building block' of client construction (see page 52). I will now give this more detailed consideration. Such consideration reflects my own endeavour to describe the organisation and consequences of members' talk.

In the extracts which follow, caseworkers demonstrate how they do vulnerability. Accomplishing vulnerability here takes on the form of a moral tale in which clients' actions and circumstances are debated. The client in the first extract is characterised as vulnerable in terms of hostel eviction (Ls.4-5). Should this event actually occur, the client would be homeless:

Extract 5:1

3 CPN2: This is - uh - Mr R Stockley — uh — they've [the hostel staff] had a few problems
4 with him at the moment. The reason I want him discussed is because — uh — that he's on
5 his final warning at Scotsway basically, and I think — do some more, or whatever.
6 Basically — what age is Ray? He's a fifty year old man. He's been homeless — on the
7 homeless circuit for about six years — since his mother died. Uh — she was staying in a
8 warden controlled flat, or whatever, so he couldn't actually stay there after she died. But,
9 uh, he looked after her — she's in a wheelchair for quite a few years — he exclusively
10 looked after her, uh, and his sisters never supported him or anything. Um, so he's got
11 quite a lot of unresolved grief about that — an awful lot of anger — but his family — his
12 sisters — have written him off now, um — so — when you can sp, when you can speak to

CPN2's utterance on Ls.4-5 constitutes the reason for bringing the client to team attention: 'he's on his final warning at Scotsway'. It also characterises the client as vulnerable in terms of accommodation. Ls.9-10 add to this characterisation of vulnerability, constructing the client's past actions as morally adequate following the death of his mother:

- he had looked after his mother (L.9)

- the description of his mother as having been 'in a wheelchair for quite a few years' (L.9) invites the inference that his role had not been easy

- at no time had he received any support from his sisters (L.10).

The team can have no way of knowing the quality of the relationship between mother and son other than the description offered to them by the CPN but their inference would be that he was caring. What is more, the CPN elaborates upon this moral description of the client adding that he had lost his accommodation upon the death of his mother. This would be 'heard' as being due to no fault of the client and as being beyond his control. In essence, this opening description of the client constructs him as the subject of a moral tale — a kind of 'tragic hero' who has done his best but who has fallen victim to life's circumstances (cf. Waller 1996). It also typifies him as the sort of client with whom the team can work.

CPN2's account is positioned within a particular kind of psychological discourse which sees the loss of meaningful relationships as contributing to illness. A new 'version' of his identity is constituted. This new identity is that of a psychologically ill person who is suffering from 'unresolved grief' (Extract 5:1, L.11).

My brief commentary on the CPN's description of Mr Stockley rests on Garfinkel's (1992) premise that descriptions have 'indexical features'. Following Garfinkel, MHT

members 'do', 'recognise' and 'use' the case accounts which they themselves accomplish in the context of their meetings. Agreement about case management is made possible because team members share and cooperatively reproduce, the same culture. In other words, they can recognise and use the ordered properties of the accounts which they cooperatively produce (1992:11). CPN2's opening description of the client is necessarily vague and incomplete, but it is not without consequence. As the full transcript would show, it establishes the client as vulnerable in terms of bereavement and homelessness so providing the grounds for continuing debate and eventual consensus. The 'context' of vulnerability is socially constructed so that the team can 'find the sense' of the description offered (Heritage 1984:154). The unfolding case account may thus be seen as the team's practical and ongoing endeavour to do this. In a sense — 'doing vulnerability' is active 'work' for the MHT and it is an important feature of its setting. Heritage would go further, suggesting that ongoing accountings of this kind actually provide the conditions for the 'maintenance, alteration or transformation' of particular social settings (1983:129).

The team's collective ability to produce a consequential context is demonstrated in the following two extracts:[1]

Extract 5:2

4 CPNC: Could I — briefly mention something?

5 Y: Go on

6 CPNC: Um, well it's very, um, an issue that came up at Hope House [hostel] and I wanted just to
7 see if other people had this happen and whether they/how they dealt with it. Um, I've
8 been seeing two or three men who are, uh, clinically depressed and who are actually um
9 — have been seen by Dr L a couple of them, and have been treated for depression. And a
10 couple — two of them are quite sort of 'retarded' and, you know, very seriously depressed

In the extract above, CPNC takes the first turn of talk and 'does' asking for permission to start. Y (the Housing Officer) takes the following turn, providing a continuer ('Go on', L.5). CPNC takes the turn provided for her (L.6) and gives an account which

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[1] Extract 5:2 has similarities with Barrett's (1996) notion of 'epigrammatic appraisals'. According to Barrett, such appraisals lay in 'the domain of commonsense reasoning' (1996:96). They take the form of short but 'telling' interactions with the patient, utilising both lay and technical psychiatric language. In Barrett's study, they serve as a bridge between psychiatric professionals and domestic cleaners. In this illustration, which contains both lay and psychiatric terminology on L.10, the interaction is between a CPN and Y, the team's housing officer.

accentuates the situation of Hope House clients who are described as 'clinically depressed' (L.8). The upshot of CPNC's account about relocating vulnerable clients is her elicitation of the possible consequences of such an act:

Extract 5:3

11 CPNC: and, um, were both on anti-depressants. And um — what's happened with them is that
12   they've become very withdrawn, and all the things you might imagine with people who
13   are depressed — and, um, have been sort of [slight laugh] — [pause] — 'snatched' by the
14   Rehousing Officers and sent down to the South Coast quite quickly when they're not in a
15   sort of 'position' to sort of [   ] — go to the South Coast, and if you are terribly low I
16   suppose you'd go, and both times with disastrous consequences in that they, you know,
17   just become more and more depressed and haven't got their medication and haven't been
18   keeping to, uh, local services, and ended up coming back again because the homes
19   couldn't cope with them. And this has happened again with a man who is — is — who
20   has got sort of, a major depressive illness, and for the first time they've actually discussed
21   with me whether I think this is a good idea for him to go, and I've said 'no'. But the client

The significance of CPNC's communicative action in Extract 5:3 (above) is that it provides a typical consequential context for clients who are designated 'depressed'. Utilised as it is as a preface to CPNC's *own* client (L.19), it provides the team with a common understanding of the most likely outcome of his circumstances. In Garfinkel's words, such an understanding entails:

'an "inner" temporal course of interpretive work (which) *necessarily*

has an operational structure . . .' (1992:31).

The common understanding here is that CPNC's client might deteriorate if he too is moved before he is fully well. Her use of the word 'snatched' (L.13) would be understood by other team members in the context of client vulnerability to which it refers.

'Doing vulnerability' is not only important work for the team and its setting; it is also a crucial narrative component in the developing 'career' of vulnerable persons (Hammersley and Atkinson 1989). The circumstances of the client's life, his or her behaviour and relationships with significant others are used by the primary narrator to

chart the client's *'rite de passage'* (Hammersley and Atkinson 1989:219). The rite of passage which is frequently charted in the MHT case accounts is that which I will term 'becoming vulnerable'. Using the example of the client already described in Extract 5:1, it is possible to see how CPN2 builds up the description of vulnerability formulated on lines 6-7:

Extract 5:4   (Part of Extract 5:1)

6 CPN2: Basically — what age is Ray? He's a fifty year old man. He's been homeless — on the
7   homeless circuit for about six years — since his mother died. Uh - she was staying in a

In the extract above, CPN2's question 'what age is Ray?' (L.6) is a useful device as it sets up the need for an answer. CPN2 supplies the answer which serves to sanction the telling of a long story. Following the client's bereavement we are told that his family (and in particular — his sisters) have 'written him off' (Extract 5:5, L.12). His ensuing 'problems' whatever these may be, are 'heard' as stemming from the fracturing of his family relationships:

Extract 5:5

12 CPN2: sisters — have written him off now, um — so — when you can sp, when you can speak to
→ 13   him — that's one of th — sort of — his immediate problems really — unresolved grief —
14   um — along with the fact that he — well — we don't know whether it's a fact yet but he
15   told us that he used [   ] to have an HIV positive test in Broughton 'bout four years
16   ago — um — and this really does seem to bother him quite a lot. Uh, he's very reluctant
17   to say how he got it — but he did admit one day that he was a practising homosexual, but
→ 18   he's not now. So I think there's a lot of guilt feelings about that as well, and it's probably
19   related to why the family has ostracised him as well so, I mean, he held down, sort of,

In the preceding extract, it is inferred that the client is 'suffering from' unresolved grief (L.13). The social circumstances of his bereavement are reconstructed in illness terms by CPN2. 'Unresolved grief' is an open-ended notion which allows for many psychological readings. Grief on its own would be 'heard' as being a normal part of life; 'unresolved' grief on the other hand could be 'heard' as pathological. The client is now reconstituted in clinical terms which renders him a suitable case for consideration by the MHT. As his grief is described as 'unresolved' — it extends the

time frame where there is the possibility of working with the client. This new description of 'ill' person compounds the existing description of vulnerability and is itself compounded by the uncertainty surrounding his HIV status (Extract 5:5, L.15). His sexual preference and behaviour ('practising homosexual', L.17)[2] is said to cause him 'guilt feelings' (L.18) — but again, like the assumptions made about his relationship with his mother earlier on in the narrative, interpretation about the client's feelings can only be speculative. Such speculation varies in the telling. In *this* context for example, 'unresolved grief' (L.13) is not set up as speculative, possibly because it relates to feelings which only the client can 'know'. By comparison, 'I think' (L.18) *is* speculative as it relates to diagnoses which are available to professionals. It could be that CPN2 is making a distinction here. The speculative nature of both descriptions however serve to strengthen the *overall* description of vulnerability which is an ongoing feature of the MHT accounts, placing it within a psychological discourse. The client's 'rite of passage' to vulnerability has been charted by the narrator.

In the following extract, the unfolding account constructs the client as having a secure past until circumstances conspire against him:

Extract 5:6

19 CPN2: related to why the family has ostracised him as well so, I mean, he held down, sort of,
20 quite a few jobs before this happened. He was a bar cellar-man and he was — he worked
21 in, um, a washing machine factory and stuff so before, sort of — up to the time his mother
22 died, um, he was — he was settled and stuff. So, basically

Throughout the case presentation the client is portrayed in a moral 'light',[3] that is

- he is constructed as a morally adequate person

- he has led a normal life in the past

- he has become vulnerable through circumstances beyond his control[4]

- he experiences psychological damage as a result of these life events.

[2] In Byrd's work 'patients with homosexual difficulties are not considered good treatment risks' (1981:61). In MHT work, such difficulties are used to construct a case.
[3] Cf. Waller (1996).
[4] Barrett's Ridgehaven work demonstrates that the moral evaluation of patients by staff is used in a different way. The Schizophrenia Team seek to transform 'a case' into 'a morally competent person' (1996:145) - one who is 'deemed capable of deciding between right and wrong' (1996:144). By way of contrast, the MHT transform persons into cases.

Extracts from two other case accounts might illustrate the preceding points and serve as comparisons with the narrative structure of Extracts 5:1 to 5:6. I will start by examining 'Sandy's case (Extracts 5:7-5:8).

Extract 5:7

4 CPNC: Right — okay— um, well the first client I want to discuss is somebody called Sandy who
5 was referred to me by Trudy at the Rockwell Centre, and she was first referred to me in
6 March of this year, who thought that Sandy was depressed, and that she wanted to talk to
7 somebody, and um — so she came to the Rockwell Centre and I saw her there. She is one
→ 8 of these sort of nightmare people. She'd been in another hostel for quite some time and,
→ 9 um, but you know where you suddenly [   ]well, what can I do? She's had a lot of therapy,
10 and she was also very sort of — up, on all the language — dynamic psychotherapy
11 and um, so I, she was quite difficult. I assessed her mental state um, when I saw her and I
12 fear she had a clinical depression, with no biological symptoms at all apart from a tendency
13 to [   ] noteworthy. She, basically, her history was that she was brought up in Baxter in
14 Yorkshire and came down to Western City with her husband, who she lived with, about
15 fourteen years ago — um — that relationship broke up and she had three children aged
16 thirteen, fifteen and seventeen. After she's split up with her husband, um, she describes —
17 from being fairly stable to having, um, multiple sexual partners, um, and losing her job
18 and living in a Council place in Monkton [long pause]. She coped quite well for quite a

The CPN's utterance on Ls.8-9 of the preceding extract provides the grounds for why this client is worth discussing ie. her case is problematic. CPNC describes the client as 'one of these sort of nightmare people' as she has 'had a lot of therapy' and is very familiar with psychotherapeutic terminology (Ls.8-10). In his Ridgehaven study, Barrett refers to such a patient as the 'professional patient' - one who is characterized as 'manipulative' and 'controlling' (1996:162).

In Extract 5:7, team members are given a description of the client, Sandy, which suggests the presence of mental illness. A member of staff at the Rockwell Centre had reported that the client might be depressed (L.6). The narrator, CPNC, also holds this opinion fearing that 'she had a clinical depression' (L.12). In the same utterance however, CPNC negates her own assessment by stating that the client has 'no biological symptoms' (L.12). An immediate repair follows on Ls.12-13 with a vague allusion to a 'tendency to [   ]'. The tape was difficult to hear at this point, but the lack of clarity surrounding the client's mental state is an ongoing phenomenon in the

text. It functions to perpetuate the inference that the client *might* be ill and is a similar device to that noted in Extract 5:1, L.11 where the client was said to be in a state of 'unresolved grief'. So even professional diagnoses can be 'appropriately' cautious[5] (see Extract 5:10 later). Again, like Extract 5:1, similar narrative elements can be detected in *this* client's case account — her 'problems' being accounted for in terms of her broken relationship with her husband (L.15).[6] CPNC's choice of the word 'relationship' rather than 'marriage' in this context, appears unusual. What is its function?

A tentative suggestion might be that it serves to position the client's experience within a psychotherapeutic discourse which has a well-developed narrative for explaining psychological disturbance in terms of relationship loss or dysfunction (McNamee and Gergen 1992:169). The combined elements of possible illness and the ending of her marriage are purported to be the start of the client's problems. We have no way of knowing anything more about the quality of this relationship other than what is offered in the text. CPNC uses it to account for the ensuing decline in her client's circumstances in a similar way to CPN2 who accounts for *her* client's misfortunes in terms of his mother's death. The client's life up to this point is described as being 'fairly stable' (L.17) but the narrator's swift move into the characteristics of the *opposite* of this state serves to mark and accentuate the client's rite of passage to vulnerable status:

Extract 5:8   (Part of Extract 5:7)

16 CPNC: thirteen, fifteen and seventeen. After she's split up with her husband, um, she describes —
17   from being fairly stable to having, um, multiple sexual partners, um, and losing her job
18   and living in a Council place in Monkton [long pause]. She coped quite well for quite a

This new description of the client suggests sexual promiscuity and failure to maintain a job as 'consequences' of the client's change of status. CPNC's use of the descriptor 'stable' (L.17) is an interesting one at this juncture as it might be heard to imply that

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[5] Pfohl states that 'discretionary vagueness' is required to preserve expert identity 'in the context of legal demands' (1978:97).
[6] Byrd cites a comparable data extract taken from a therapist's written notes about a female client: 'Her depression probably stems from her husband leaving her for another woman' (1981:77).

it is a feature of her mental state as well as her social situation. Having already been told that the client might be 'depressed' (Extract 5:7, L.6) talk of stability or otherwise at this point in the story serves to reinforce the overall picture of vulnerability. By L.24 (not shown) following the client's perceived abandonment of her children — she is described as being 'out of control'. Again, the severing of significant relationships is used to account for the sudden change in her circumstances and her residency in a hostel for the homeless (L.26 not shown). The passage to vulnerability is complete — at least for this phase of the account, but the ascription will be continually debated by other team members as the client's case history unfolds.

The second case describes the situation of a male client named 'Tony'. The client is considered to be particularly at risk from losing his hostel place because of behaviour associated with mental illness for which he has refused treatment. The case is presented by G who is a Community Psychiatric Nurse. In Extract 5:9, L.4, below - G gives his reason for presenting the case. L.9 ('on closer interview') bears testimony to his skills:

Extract 5:9

→ 4   G: Well — a very quick mention of somebody I'd like to share information with. It's a chap
5   called Tony who's, uh, twenty — nine year old man still living in Hollyview. I picked him
6   up there in July of this year. Ah — main reason for referral was that he was very very pre-
7   occupied with religious tapes and that he thought there was some sort of 'gangland' people
8   after him. And — when I saw him he was [pause] — a very pleasant um, very nice pleasant
→ 9   man — but on closer interview, he was holding a lot of very elaborate delusions and ideas
10   about people knowing what, uh — plotting against him. And on subsequent
11   interviews in actual fact — the Home Office were after him and everybody he thinks was
12   against him/were watching him across Hollyview to the flats. And so, I got [name of Dr]
13   to see him, and [name of Dr] thought the same — give him some Sulpiride and asked me
14   to discuss it with him, uh, whereby he reacted extremely badly to my suggestion of
15   medication and stormed off. And so I — so I held back seeing him for a couple of months
16   just keeping sort of — very loose contact with him in the corridor which he seemed very
17   able to handle. However, um, yesterday while I was at Hollyview I heard all this shouting
18   in the street, and saw him shouting across the flats across the way

19   [POLICE CAR GOING BY WITH SIRENS WAILING]

20   and I thought, it's the first time I've seen him sort of 'reacting' to perhaps a delusional
21   thing. In actual fact, what had been happening was that he had recently been seen by the
22   Welfare Officer who felt that he would have to leave Hollyview. And the main reason was

23	that there had been a spate of thieving from the men's lockers, and Tony had been
24	suspected of stealing from the residents, which quite concerned him. When he was doing
25	his washing, his laundry, other men try, sort of — to stop him, and things like that. Although
26	nobody has actually proven that he is the culprit, all the other residents have sort of feelings
27	about this. So [pause] — he may have to be transferred to Hope House or James Bell
28	[hostels] by Monday. So — just letting you all know that he's somebody that

The account of *this* client's history is structured in very similar narrative terms to the other two although the description of him by the narrator is more heavily inscribed with the inference of mental illness. We are not told the precise nature of the illness or whether indeed the client is ill at all, but again the description is left sufficiently open for the presence of illness to be a possibility. Despite the lack of definition — G still uses it to account for the client's behaviour (Extract 5:9, Ls.17-21). It is not a categoric statement as Extract 5:10 shows, but is full of qualifications mitigating the description of the behaviour so that it permits a wide range of interpretation and/or response. In this sense it is more indexical than Extracts 5:1 and 5:7.

Extract 5:10 (Part of Extract 5:9)

| → 20 | G: | and I thought, it's the first time I've seen him sort of 'reacting' to perhaps a delusional |
| 21 | | thing. In actual fact, what had been happening was that he had recently been seen by the |

The utilisation of 'sort of' and 'perhaps' on L.20 in the extract above serve as 'cautious' describers of the client's behaviour and possible mental state but succeed in maintaining an element of doubt about both. The turning point in *this* account is reported to be when the client was seen by the welfare officer with a view to being transferred to another hostel (Extract 5:9, Ls.21-22). Again, the description of events which is used to account for this circumstance (suspicion of stealing from residents, Extract 5:9, Ls.23-24) remains flexible with G describing the client as morally adequate (L.26). Nobody has actual proof that the client is responsible but the implication stemming from this disclosure might mean — or indeed, *does* mean — that the client will have to leave the hostel. As with the clients in Extracts 5:1 and 5:7 — the loss of a significant relationship or relationships is an important component in accomplishing vulnerability, the 'relationship' in Tony's case being a hostel, rather than a person. By inference, 'hostel' would be heard as 'home' with all its attendant

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relationships. We are not party to how the client 'feels' about living in Hollyview, or whether or not he actually *minds* about living elsewhere. But G consistently characterises him as vulnerable throughout the narrative. Pervading the entire account is the inference that it is somehow detrimental for the client to be moved before a formal medication régime has been established (Extract 5:9, Ls.13-15).

As I have already discussed at the beginning of this chapter, MHT clients are constructed as vulnerable primarily in terms of their mental health. The possibility of becoming homeless is grounded in this characterisation of 'vulnerable person'. 'Doing vulnerability' is ongoing work in the MHT case accounts but it has greatest prominence in the case presentation. It is not a once-and-for-all description but is one which is subject to continuous challenge. The description is very flexible but it suffices for the work at hand. Extracts 5:11 to 5:16 illustrate how MHT members construct and use such descriptions of the client.

In Extract 5:11, the client is immediately constructed as being vulnerable in terms of housing, L.9:

Extract 5:11   (Part of Extract 5:12)

8 OT: Shall I start then? Okay. This gentleman Mr Dunton who was referred to me by J from the
9   Downtown Team, um, he came for help with housing. He was referred to her, um —

In Extract 5:12 (over page) as the story unfolds, the same client is described in terms of mental illness. In the initial stages of the narrative his 'past psychiatric history' (L.11) and 'a brief hospital admission' (L.13) are invoked. The admission is described as being 'due to a brief hypomanic episode' (Ls.13-14) which clearly establishes the client in illness terms. This characterisation of a sick person continues. The client's two episodes of hypomania for which he was hospitalised in Germany (L.13) and at St. Magna's Hospital (Ls.16-17) are offered to the team by OT by way of further underlining the client's mental health status. This characterisation of the client as someone who is vulnerable in terms of his mental health culminates in OT's utterance

that his referral is attributable to 'hallucinations' and 'grandiose ideas' (Ls.23-24).[7] He is also described as being 'quite disturbed' (L.24) when J, a member of staff from the Downtown Team, sees him. This characterisation of a vulnerable person is a very powerful one in the context of the MHT case conference. It would be inferred by members of the same 'language community' that this client might be mentally ill (Garfinkel 1992:29).

Extract 5:12

8 OT: Shall I start then? Okay. This gentleman Mr Dunton who was referred to me by J from
9 the Downtown Team, um, he came for help with housing. He was referred to her, um —
10 the reason for referral was to assess his, uh, daily living skills — he didn't have these
11 skills particularly [   ] He hadn't lived alone before. His past psychiatric history,
12 um, dates back to about four years ago when he was in Germany. He'd come from
13 England to [name of town] Germany. After a brief hospital admission there due to a brief
14 hypomanic episode he then left Germany — went to Holland for a while — to live for a
15 year — and then came back.

16 At the beginning of this year, at the end of March, he was admitted to St. Magna's
17 Hospital — again, a hypomanic episode, and he was discharged following treatment, two
18 weeks later. He was then discharged to friends who lived in a two bedroomed flat and
19 they said that they would help. A week — ten days later, he was re-admitted to St.
20 Magna's — again, a hypomanic episode, and his friends didn't know what was wrong
21 with him. He was discharged on the seventeenth of April [   ]

22 [COUGH]

23 where, he was referred to J again, um, said to be hal/hallucinating and having grandiose
24 ideas. He was quite disturbed when J saw him

Extract 5:12 does not constitute a 'moral tale' as such (cf. description of client in Extract 5:1). But it *is* part of a case history where the 'meaning' of the life in the text is located (cf. Denzin 1989:33). Atkinson reminds us that meanings arise through 'conventions of telling' (1991:105). OT's 'telling' has meaning for the team to which it is addressed.

Occasionally, client vulnerability is constructed in terms of *physical* ill health as Extract 5:13 demonstrates. This case is presented on similar grounds to that of Extract 5:2. It represents a member's call to discuss a topical event. In Extract 5:2 the topical

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[7] In Pfohl's (1978) study, the reported presence of mental illness is dependent on one of three psychotic symptoms. These include 'the manifestation of delusional thinking' and 'the manifestation of hallucinations' (1978:99). Such symptoms are included on the MHT's assessment form (refer to Manchester Score Sheet, Appendix 3).

event is the perceived 'poaching' of severely ill clients by rehousing officers. In Extract 5:13 which follows next, the topical event is a physically ill client who will need housing following discharge from hospital. Ordinarily, physically ill clients would not come within the remit of the MHT.

Extract 5:13

3	M:	Um [pause] — has anybody got any ideas about housing for somebody that I, uh, have been
4		seeing? His name is Fred Turner and he's, um, fifty three year old and he's — at the
→ 5		moment he's in Queen Margaret's Hospital in Corrington with ten per cent burns. Um —
6		he's been in about a month. He was doing quite well up till about two weeks ago when he
7		stopped eating and drinking so he's become very weak and is being fed through a tube up
8		his nose and [he's] also become incontinent so he's got a bag as well so he's not, um, in
9		any condition to have anyone come and do an assessment in Community Care, um —
10		though Ben and I referred him to Ashvale Social Services

In the extract above, M, the team's social worker, characterises the client in terms of physical illness. The team is told that the client has 'ten per cent burns' (L.5) and that he has been hospitalized (L.5). His condition has deteriorated so that he has to receive artificial feeding (Ls.7-8) and catheter drainage (L.8). Client description in terms of physical ill health is not an ordinarily encountered phenomenon for the team, and it is questioned by G with the next turn of talk:

Extract 5:14   (Part of Extract 5:18)

11	G:	You say he's there for burns?

M reinforces the original description ('Burns. Yeah' in Extract 5:18, L.12) but again G seeks clarification, Extract 5:15, below:

Extract 5:15   (Part of Extract 5:18)

13	G:	How did he get the burns?

In Extract 5:16, M takes the next turn of talk which represents a response to G's request for clarification. It also functions to bring new knowledge about the client to the team's attention — that of the client's 'speech impediment'(L.15). The implication

of this new knowledge is that it is difficult to hear what the client is saying. This provides the grounds for establishing doubt about the client's mental health status. It also provides for a new characterisation of the client ie. as one who is vulnerable in terms of his mental health. As with cases mentioned earlier, client description is accomplished in sufficiently open terms to allow for future endorsements and/or challenges as the account progresses:

Extract 5:16

14 M: Um — no one really knows. Ben feels that someone set light to him. He's somebody that
→ 15   has very, uh — he has a speech impediment. It's difficult to hear what he's saying and
16   we're quite sure he has mental health problems but what they are — we don't know —

A summary of the preceding section will now be given. 'Doing vulnerability' provides the team with a typical context for case work. Case accounts function as a cultural resource which can be used by the team to make sense of its work (Garfinkel 1992). Client description which conveys and constructs vulnerability is thus important work for MHT members in terms of their culture and philosophy of care. It provides a context for debating the morality of clients' actions. I now want to analyse how the morality of client actions is accounted for and debated.

5.2 The morality of clients' actions

Morality is important to the team's characterisation of clients because it is utilised in members' debate on the client's actions. The grounds for team intervention are constructed through members' deliberations. The main theoretical influences I will use are: Garfinkel's (1992) indexical features of description, McHugh's (1970) analysis of the nature of deviancy and Dingwall and Murray's (1983) work on the categorisation of patients by health care professionals.

In this section I will explore McHugh's theory of the nature of deviancy using examples of some of the case extracts already cited earlier in this chapter. To begin

with Extract 5:12. This case account describes the situation of a twenty-four year old client who has been referred for a housing and daily living skills assessment. The occupational therapist's case presentation of the client and his circumstances utilises descriptors suggestive of mental illness. All OT's utterances regarding mental illness are heard as 'constraining' factors. The client is established very early on in the account as being an 'ill person' whose actions become pre-theoretic using McHugh's concept. In this way, the client's status is defined as conventional/pre-theoretic.

This definition has consequences for assessing the client's responsibility as Dingwall and Murray's (1983) adaptation and extension of McHugh's concept indicates:

Table 5.1: Clients as pre-theoretic

	Conventional	Non-conventional
Theoretic	A. Breaks rules Responsible	B. Breaks rules/unavoidable Responsible
Pre-theoretic	C. Breaks rules Not responsible	D. Breaks rules/ unavoidable Not responsible

From: Dingwall and Murray (1983:135).

Dingwall and Murray's research took place in the accident departments of four hospitals (1983:129). They suggest that if staff assess patients as being able to make choices (theoretic), and that if the situation the patient is in is seen to allow choices (ie. a conventional situation) — then a 'label' of deviancy might be given. Patients who do not cooperate either with staff or treatment are defined as 'bad' (Dingwall and Murray 1983:134). Children are regarded as exceptional cases and are almost always defined as pre-theoretic. However, if circumstances suggest that the patient did *not* have choices (ie. non-conventional) then different labels are ascribed. Non-conventional/theoretic patients are defined as 'inappropriate' and non-conventional/ pre-theoretic patients are defined as 'naive' (Dingwall and Murray 1983:140).

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Decision-making in this setting is very complex as it is in the MHT setting and it is accomplished through the use of interacting frames (see Chapter Six). The twenty-four year old MHT client of Extract 5:12 would be categorised as a Category 'C' client using Dingwall and Murray's schema because he breaks rules but is not perceived to be responsible for this because he is mentally ill. The presence of mental illness would be heard as a constraining factor in the context of MHT casework. According to Dingwall and Murray such a categorisation would lead to 'rehabilitative efforts' (1983:135). The client in question would not be seen as having alternatives, and he could not know what he was doing because OT had postulated that he was mentally ill. This would be 'heard' as absolving him of responsibility for his actions. McHugh himself gives the example of the reputable poor:

'though soon parted from their money, are not called foolish because there are thought to be no alternatives. The poor's loss is deemed inevitable, the fool's not . . .' (1970:158).

Similarly, the client with a history of mental illness.

Equivalent 'work' is being done by CPNC in the following extract:

Extract 5:17   (Part of Extract 3:4)

19 CPNC: couldn't cope with them. And this has happened again with a man who is — is — who
20   has got sort of, a major depressive illness, and for the first time they've actually discussed
21   with me whether I think this is a good idea for him to go, and I've said 'no'. But the client

A person described as having 'a major depressive illness' (L.20) would be 'heard' in mental illness terms — the severity of the illness being upgraded by the precursor 'major'. The invocation of mental illness functions as a constraining factor so that the agent would be defined as conventional/pre-theoretic. As such, he would not be perceived as being responsible for his actions (McHugh 1970:153). However,

McHugh warns against the error of simplification in regarding the procedure of rule-following as being one of merely matching behaviour to rules (1970:178).[8] He suggests that we should not only scrutinize the act, but also the *kind* of rule:

'by which the act can be a course of action' (1970:178).

Like the client referred for a daily living skills assessment in Extract 5:12, CPNC's depressed client in Extract 5:17 would also be a Category 'C' client — eligible for 'rehabilitative efforts' from the team (Dingwall and Murray 1983:135).

What of the client with burns in Extract 5:13? His case is slightly different from that of the clients already cited as he is initially characterised as vulnerable in physical illness terms. Following McHugh (1970:159) the client cannot be perceived as an agent of his own behaviour or his actions as motivated because of his impaired physical health, but M's definition is questioned:

Extract 5:18

11 G: You say he's there for burns?

12 M: Burns. Yeah

13 G: How did he get the burns?

This brief exchange amongst team members represents 'facts' which all can accept. G's question on L.13 is crucial as it provides the grounds for a client definition of conventional/theoreticity. Such a definition would place the client in Category 'A' which 'attracts . . . punitive treatment' (Dingwall and Murray 1983:135). But a 'charge' has to be brought before a deviant act can be labelled as such and M manages the potential challenge from G by giving fresh information which is sufficiently vague to allow the client to be defined as pre-theoretic:

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[8] Pfohl's (1978) study demonstrates that members' interactions only *appear to be* rule governed. Pfohl states that rules 'are embedded as "ad hoc" displays of rationality or accountability in the occasions of their use' (1978:220).

Extract 5:19

14 M: Um — no one really knows. Ben feels that someone set light to him. He's somebody that
15 has very, uh — he has a speech impediment. It's difficult to hear what he's saying and
16 we're quite sure he has mental health problems but what they are — we don't know — and
17 on his report when I was there the Psychiatrist had put down Wernicke's
18 Encephalopathy, um, but the additional things the Psychiatrist had said like — short term

In the extract above, additional information about the client's 'speech impediment' (L.15) is offered, as is a vague allusion to unspecified 'mental health problems' (L.16). G's question is *not* heard as a challenge to the client's status as it puts M's utterance within the clinical frame. By addressing issues of theoreticity and conventionality G's question provides M with an opportunity to open up the account. The response that she gives on Ls. 14-18 demonstrates that its relationship to the circumstances it describes is 'loose' (Garfinkel 1992:2). The indecisive nature of the client's mental illness is compounded by the drawing of members' attention to the 'fact' that the Queen Margaret Psychiatrist had recorded a diagnosis of 'Wernicke's Encephalopathy' (Ls.17-18) — a disturbance of memory associated with heavy drinking. The element of doubt regarding the client's mental health status remains.

The MHT case examples selected thus far, typify clients who are categorised as Category 'C' (Dingwall and Murray 1983:135) or whose categorisation is upgraded to Category 'C' as in the case of the client with burns (Extract 5:19). But what are the characteristics of the narratives of clients told by the MHT who are categorised as Category 'D' which Dingwall and Murray define as 'a source of amusement' (1983:135)? A further case will be used here to demonstrate how this category is employed in MHT practice.

Extract 5:20

3 G: Yeah — I've got someone that I've been working with for some time sort of [a] — problem
4 [pause]. The other thing is — I have to leave from here promptly at twelve so

5 TL: Sure

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 6   G:      Um — he's somebody that you'll probably remember; his name is Desmond Dooley.
 7           He's — uh — forty eight year old man who was referred to me last year from Hollyview
 8           [hostel] and at that time he was referred because he was depressed and he was drinking a
 9           lot. And — when I/through the course of my interview it wh/what was very clear was that
10           his drinking was really a big problem in the past and up to the point when he was at
11           Hollyview. So I referred him to [the] Therapeutic Community Substance Abuse
12           Community Team, Shiretown, whereby he became more and more clinically depressed
13           because he just couldn't handle the Community at all. And he walked out — came back to
14           Metropolis — and I had to get him admitted to the North Eastern Hospital, and he was
15           there for a few weeks over Christmas — and — the beginning of the year, he was
16           transferred to St. Hilda's [hospital] where he was discharged to bed and breakfast. I
17           managed to keep in contact with him right through — the bed and breakfast — and he was
18           on Greenton's housing list
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This forty-eight year old client is presented to the team by G, a CPN. The client is already known to the team and is characterised in mental illness terms from the outset of G's presentation:

Extract 5:21   (Part of Extracts 5:20 and 5:22)

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 8   G:      [hostel] and at that time he was referred because he was depressed and he was drinking a
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This establishes the client's status as pre-theoretic, 'depression' being 'heard' as a mitigating factor in any debate about the client's actions and the degree of responsibility assigned to him for his actions. However, there could be a problem with this description of client depression as it is linked with heavy drinking:

Extract 5:22

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   8   G:    [hostel] and at that time he was referred because he was depressed and he was drinking a
   9         lot. And — when I/through the course of my interview it wh/what was very clear was that
  10         his drinking was really a big problem in the past and up to the point when he was at
  11         Hollyview. So I referred him to [the] Therapeutic Community Substance Abuse
→ 12         Community Team, Shiretown whereby he became more and more clinically depressed
  13         because he just couldn't handle the community at all. And he walked out —
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This new information constitutes an alternative description of the client which has the potential to place him in Category 'A' (conventional/theoretic) — 'breaks rules/ responsible' according to Dingwall and Murray's classification (1983:135). G skilfully

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manages this potential trouble by redefining the client in illness terms (Extract 5:22, Ls. 11-12), and by relegating the client's alcohol problems to history:

Extract 5:23   (Part of Extract 5:22)

→ 10 G: his drinking was really a big problem in the past and up to the point when he was at
11   Hollyview. So I referred him to [the] Therapeutic Community Substance Abuse

This leaves the way clear for the client to be retypified as ill ('more and more clinically depressed', Extract 5:22, L.12). By downgrading the client description in terms of his alcohol history G manages to pre-empt any challenge that might emerge to the client's pre-theoretic status. Having accomplished this, he is then able to 'work up' the description of a sick person so that the pre-theoretic definition is reinforced. All line numbers refer to Extract 5:20:

- the client was referred to the Therapeutic Community Substance Abuse team in Shiretown (Ls. 11-12)
- this referral designated him 'clinically depressed' (L.12)
- he discharged himself from the Therapeutic Community and was admitted to the North Eastern Hospital (Ls. 13-14)
- he was eventually transferred to St. Hilda's Hospital (Ls. 15-16).

But this new definition of the client is immensely fragile as it is subject to constant revision throughout the case discussion. On *this* occasion G has emphasised the mental illness 'reality' rather than the alcohol using 'reality' so safeguarding the client's pre-theoretic status, but the client's new found independence in bed and breakfast accommodation (Extract 5:24, L.16) 'deletes' his client status altogether:

Extract 5:24

15 G: there for a few weeks over Christmas — and — the beginning of the year, he was
16   transferred to St. Hilda's [hospital] where he was discharged to bed and breakfast. I
17   managed to keep in contact with him right through — the bed and breakfast — and he was

18	on Greenton's housing list. Um — he/since then, [he] has been rehoused to his own flat in
19	North Railton and he's really done very well in terms of furnishing it and sort of — getting
20	a few things sorted out — and he's got a network of some friends in the bed and breakfast.
21	His ex-wife, wh/who lives in Greenton, keeps regular contact

Not only has the client succeeded in re-establishing his life outside of hospital — he has also succeeded in doing this almost entirely by his own efforts. This constitutes a difficulty for the team and is an irony as a client coping so well would not require its help. But coping helps in the moral tale (cf. Silverman's cleft-palate patient, 1987:184)[9]. In Extract 5:25, G manages this trouble by confronting the client's rehabilitated status. He accomplishes this by informing the team about the client's 'unrealistic' (L.25) preoccupation with his genitals:

Extract 5:25

24	G:	The/when I was seeing him last year, one of the things that came out was that he has this
25		almost [pause] — I don't know, at that time he seemed almost sort of — unrealistic — idea
26		about his genitals. He thought there was something wrong with his genitals. I referred him
27		to Dr Tamar who thought — yeah [laughing] — there might be something wrong so — he
28		referred him to St. Hilda's GU Clinic, or something like that — and while he was an in-
29		patient at the North Eastern, the appointment

This immediately redefines the client as pre-theoretic as he was said to have 'unrealistic' ideas about his genitals ie. by inference, ideas not grounded in rationality. It also places the client in Category 'D' of Dingwall and Murray's classification (non-conventional/pre-theoretic) which they suggest can be a source of amusement:

'marking the rule-breaking without attacking the moral character of
the rule-breaker' (1983:135).

An episode of laughter is located on L.27 (Extract 5:25) but it is bound to the reported thoughts of Dr Tamar rather than to any member of the team.

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[9] The patient referred to in Chapter Seven of 'Communication and Medical Practice' (1987) is an adolescent named Simon. Simon laughs and jokes with the doctor in the cleft palate clinic but he is also able to demonstrate to the doctor that he is fully aware of the implications of surgery and will put up with the discomfort.

Later on in the account, G reports that the client has been to Greenton Social Services to ask for support in looking after his step-grandchildren (aged nine and ten) who have been abandoned by their mother:

Extract 5:26

→ 59	G:	So he went to Greenton and asked for help, and Greenton said: Really, it's not our
60		responsibility [background laughter]; it's Wilmington's responsibility 'cos really, they
61		shouldn't do that; it's disgusting — blah, blah, blah. The good thing is, he's got uh —
62		John Curling — his Social Worker at St. Hilda's — who's been trying to sort of — tie this
63		up a bit. But even so, up till now, he's been caught up in between. But Desmond himself
→ 64		feels he's able to look after them. He is giving support — like — with his money. And he
65		doesn't really want them to go back to Tricia in a sense because he — uh — the step
66		daughter's behaviour is really, he says, basically, she's [a] one man a week kind of person.
67		And, at the moment, she's got another man she wants to move in with — that's why she's
68		taken the kids out so that she can get on with her drinking and her — you know — her
69		sort of life. So he thinks that in actual fact, it would be detrimental for them to go back.
→ 70		Also, the fact that Wilmington Services seem to be so poor, and he's quite disappointed
71		with them. But, at the same time, they're stuck in this flat with him, and they're not legally
72		his responsibility — and he's — he's actually doing very well. He's very very caring; he's
73		feeding them; he's, you know — getting things [done]

In the extract above, G does some 'facework' which reinforces the picture of a caring person (Strong 1979):

- he went to Greenton Social Services to ask for help (L.59)

- although his step-grandchildren are not directly his responsibility he is supporting them with his money (L.64)

- he is seen to be protecting the children from Tricia, his step-daughter, because her lifestyle is not considered acceptable in terms of 'good motherhood' (Ls.65-69)

- he is disappointed with Wilmington Social Services (Ls.70-71).

Following Strong, G's new description of the client serves as an attempt to preserve the client's ideal image at this stage of the team debate (1979:41). Dingwall and Murray suggest that 'orienting principles' used to classify patients can be utilised:

111

'to make predictions about the way patients will be treated'
(1983:132).

In the MHT setting, clients constituted as pre-theoretic or theoretic orient members to the rules of their particular work. In Chapter Six where I analyse team use of frames, data drawn from MHT casework will be examined to explore the relationship between pre-theoreticity and a client description as 'good' or 'bad' (Jeffery 1979:92). However, before starting this examination, I will tell the reader how information about potential clients is brought to team attention.

Fieldwork notes from the early stages of data collection indicate that the team does a proportion of its work by telephone. Enquiries from community care agencies using the MHT as a resource, or from individuals seeking help directly are sometimes managed adequately by means of a single telephone call. The use of a rating scale designed to elicit psychiatric symptomatology 'edits out' a number of potential clients at source (Manchester Rating Scale)[10]. Some clients are directed to other agencies following an initial assessment by a MHT caseworker. They cease to be the concern of the team following referral. The cases which *cannot* be managed in either of these ways are presented for team discussion. Jeffery suggests that in the hospital casualty department setting, 'good' patients are those described in 'medical' terms (1979:104). In MHT practice, homeless mentally ill clients constitute 'good' clients. Such clients represent 'interesting' cases.[11] However, some cases are constituted as more appropriate than others so that a 'scale' of appropriateness is implicit in casework talk. This is best illustrated by means of a diagram:

[10] See Appendix 3.
[11] This is very different to Byrd's (1981) research where a similar client group (ie. those who had chronic problems) were referred to a clinic for supportive care. The objective of care in this clinic was client support and maintenance rather than therapeutic change (1981:11). Intelligent and articulate clients were 'interesting' cases in Byrd's study (1981:126). In Barrett's (1996) study also the chronic patient is not defined as 'interesting' having nothing new to offer staff in respect of testing their skills (1996:175).

Table 5.2: Mental Health Team casework

Inappropriate Cases	Just Appropriate Cases	'Good' Cases	Exemplary Cases

I will now provide a summary of morality and theoreticity.

5.3 Morality and theoreticity: an overview

Clients defined as pre-theoretic are not held responsible for their actions because they are constructed as vulnerable in terms of their mental health. However, client definitions are fragile and can be challenged by team members at any point in their discussion. Appropriate cases are those which 'fit' MHT concerns.[12] A client defined as theoretic would not enable the team to demonstrate its competency. In the next section, and in Chapter Six which follows it, I will examine how members manage the contingencies of their work through the use of frames.

Clients' stories are offered to team members by individual case workers and 'shaped and moulded' in the process (Prior 1993:4). This discussion of mentally ill-single homeless people is characterized by the 'co-presence' of a number of different frames (cf. Peräkylä 1989). It is within these frames that team members expose the client to their 'knowledge and involvement' (Peräkylä 1989:117). Strong (1979) also testifies to the use of a variety of different frames in his observations of medical encounters. For Strong — framed activities are 'historically situated' and they change according to 'different circumstance' (1979:12). Framing clients in MHT work is both an historically situated and collective act where the team's case working reality is 'socially produced' (Atkinson 1995:4).

In the chapter which follows, consideration will be given to how framing is enacted in the MHT setting. I will also show how frames allow us to see how caseworkers construct 'appropriate' and 'inappropriate' clients. The team's use of a bureaucratic frame to manage an anomalous case will be discussed.

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[12] In Byrd's study, the process of client selection 'meets fundamental organizational needs' (1978:3). Byrd also refers to the phenomenon of 'buffering' through which staff alter client characteristics so that their professional expertise can be utilized more efficiently (1978:3).

Chapter Six: Constructing the Client II

The main theoretical influence I will use in this chapter is Goffman's (1974) frame analysis. Goffman's (1974) concept of 'framing' opens up variability of meaning in a given situation. For Goffman, framing is a dynamic concept which provides an analytic base for dealing with ambiguity (1974:307). It organises meaning but it also organises 'involvement'. Reconstitutings in talk thus have very real consequences in practice. For example, Maynard observes that people 'demonstrate' their 'orientations' to difficulties and issues which have relevance for them through structures of talk and interaction (1988:312).[1] Gubrium found that local cultural frames were decided upon from the perspective of their relevance for a particular contingency in his work at Cedarview (1989:98).

How are frames used in MHT practice? In response to the dynamics of the MHT's moral debates, a number of different frames of reference emerge. For the purposes of description I title these: the 'clinical' or 'psychological', the 'ethical', the 'practical', the 'legal', and the 'bureaucratic' frames. Each frame is defined by the function it fulfils in the account. It is identified by the particular terminology it invokes relating to the discourse which takes place within it. Changes of frame or laminations to existing frames occur in response to verbal challenges to the client's pre-theoretic status. They also occur in response to perceived challenges to the working practices of the MHT and to its philosophy of care (cf. Peräkylä 1989:123).

6.1 Framing

Frame changes and laminations produced through MHT discussion are demonstrated in the following case extracts. The first extract refers to a client already cited in Extract 5:12 — a male client referred for a housing and daily living skills assessment. In Extract 5:12, Ls. 8-23, OT's opening characterisation of the client is largely conducted

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[1] Pfohl's 1978 study of Lima State Hospital examines patient re-evaluations by psychiatric professionals. In this study, Pfohl is concerned with the methods which professionals use 'to convince themselves and others that the inner (or psychiatric) reality of patients is structured in a particular fashion (mentally ill, dangerous, psychopathic)' - p.7. Also cf. Barrett (1996:1) who examines how clinical staff construct patients as 'cases of psychiatric illness'.

in the clinical frame.[2] In Extract 6:1, a challenge to the client's pre-theoretic status arises from within this discourse with new information regarding the client's history:

Extract 6:1

24	OT:	..... He was quite disturbed when I saw him. At this stage, he had been banned from St.
25		Magna's from the ward he's been attending, um, due to persistent behaviour problems —
26		weren't they — which they felt weren't due to his mental state [ ], so there were
27		negotiations about his being referred back to Ward Five

28	CPNC:	He was, what happened was that St. Magna's said they couldn't support [him]. The security
29		guys I think, got a bit fed up of him — keep removing him, and he's just got this thing about
30		going back to the ward now because going to the ward and saying how he felt — no
31		understanding or anything — hopeless. And then he actually threatened a couple of
→ 32		members of staff who tried to talk to him. The security men kept removing him and in the
→ 33		end they decided they'd have to [ ].

| 34 | | So they took him to court and got an injunction, and he wasn't allowed to go within so |
| 35 | | many yards of Ward Five or something like that [laughter] |

| 36 | G: | Never heard of that before |

In this context the client's actions are perceived as theoretic because they are not attributable to mental illness. Ls.32-33 demonstrate how the frame changes from the clinical to the practical and to the legal, with talk of an 'injunction' on L.34. The client's categorisation also changes with this move out of the clinical frame and he becomes newly defined as conventional/theoretic — a Category 'A' client according to Dingwall and Murray who 'attracts . . . punitive treatment' (1983:135). The client in this situation is literally 'breaking departmental rules' and the hospital has had to resort to legal sanctions in order to prevent him returning to Ward Five. This challenge to the client's pre-theoreticity is managed by a shift of frame back into the clinical. The episode of laughter in Extract 6:1, L.35 - signals the change of frame. It also redefines the client as Category 'D' which marks the rule-breaking 'without attacking the moral character of the rule breaker' (Dingwall and Murray 1983:135). The upshot of this episode of laughter is G's taking up of the next available turn. His utterance: 'Never heard of that before' (Extract 6:1, L.36) constitutes the ward staff's actions in acquiring an injunction as inappropriate. This functions to distance the ward staff and to position the MHT as contenders for the client's care.

[2] This compares with Byrd's observation that professionals 'typically assume pathology in their initial transactions with clients' (1981:45). This is particularly marked when availability of places in the outpatient clinic is high (1981:138). When availability is low, Byrd states that staff are more likely to construct clients as being responsible agents of their own actions.

The utilisation of the clinical frame is demonstrated in the next extract which is a continuation of Extract 6:1. CPNC takes the turn made available by G on L.36:

Extract 6:2

37 CPNC: And that's what happened. They then discharged him to Hope House. Immediately he
38   was just sort of very bizarre, and they [the hospital staff] said that they felt that he did
39   need help, but he didn't need to be on the ward so

40 DR: Are they organising any help for him do you know?

41 CPNC: Well — I think that they thought that by sending him to Hope House [hostel] he'd be
42   picked up you see

43 G: In *minutes* isn't it? [general laughter]

44 CPNC: It is — yes

45 G: In a letter or just

46 CPNC: No, no. He just sort of arrived at Hope House talking about, um, how he was God

47 OT: So, has he been admitted to St. Magna's Hospital?

48 CPNC: Oh — they wouldn't take him back — no. But, um, course — as soon as he went out on
49   the street — they picked him up and took him back to [laughing] — so they got him back
50   anyway

→ 51 OT: Admitted on a [Section] 137?[3]

52 CPNC: Yeah [long pause]. Don't quite know what to do

53 OT: He was referred to me, then, at the end of August 'cos again he had been treated for/his
54   mental state had deteriorated. Can I just give you some brief outline of what I found?

55 G: Mm

In the extract above, CPNC characterises the client's behaviour as 'bizarre', L.38. She also infers that the client might be deluded because she reports him as saying that he is God (L.46). He was 'picked up' when he appeared on the street and it is inferred (but not stated) that he was taken back to hospital ('took him back to', L.49). The client's return to his original pre-theoretic definition is reinforced by OT's utterance that he was admitted to hospital 'on a Section 137' (Extract 6:2, L.51). This refers to

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[3] Section 137 of the Mental Health Act 1983 gives 'Provisions as to custody, conveyance and detention' of persons detained under its remit. Persons detained 'in a place of safety' are 'deemed to be in legal custody' (p.105).

a section of the Mental Health Act 1983 under which the client is legally detained. This would be 'heard' as a strong invocation of clienthood within the context of the MHT. It functions to restore the client's pre-theoretic status so that he is again someone with whom the team can work. The two episodes of laughter in Extract 6:2 (Ls.43 and 49) both function to characterise the hospital staff's actions as inappropriate. The episode which is the upshot of G's utterance on L.43, marks the inappropriateness of discharging a disturbed client to a hostel. The episode on L.49 marks the inappropriateness of refusing hospital admission to a disturbed client. Like the episode of laughter in Extract 6:1, L.35 — those on Ls.43 and 49 also function to distance the hospital staff and position the MHT as contenders for the client's care. However, in this instance, the laughter has an additional function in that it characterises the hospital staff as incompetent so marking the MHT as experts.

A change of frame to the practical marks the team's accomplishment in which OT begins her account of the client's daily living skills assessment. In Extract 6:2, G provides a continuer, 'Mm' (L.55) enabling OT's move into the practical frame on L.56:

Extract 6:3

56 OT: I asked Mr Dunton in a previous meeting, to plan a menu which he wanted to cook, and

The next extract deals ostensibly with client care. As the narrative unfolds however, it becomes clear that the issue being debated is that of procedural rules. Such rules underpin the working practice of the team and facilitate its everyday interventions with clients. The case is presented by CPN2, a Community Psychiatric Nurse:

Extract 6:4

3 CPN2:   He's a forty year old man, Caucasian. Basically, just um — if he should come into the
4   area — I've got the info on him here — he shouldn't be seen alone by any women. That's
5   the only information I've got. I'm going to chase up some notes from Fernley — Special

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6   Hospital in Wolverton, on him — but that was, uh, pretty strong advice I got from one of
7   the workers. He's in Metropolis Day Centre — but he's now, lost to them — so the feeling
8   is, he might come back into this area

9 Y: Where is he — where is he based down at Downtown?

10 CPN2: Uh

11 G: Greenton Walk In

12 CPN2: Greenton Walk In, asking for counselling — past history of psychiatric care. He's staying
13   on [pause] a friend's floor, temporarily. It's just that it's information I've got from
14   Metropolis, um; he's got a long forensic history, but I'll wait for notes — but apparently,
→ 15   in the Metropolis Day Centre, he's a very dodgy character to have around women. And
16   something came out in a psychotherapy session that uh — his forensic involvement with
17   his girlfriend. I'll just wait for — it's just an alert really. He — I have actually put him on
18   the computer if he wasn't on it before. Then — he'll be discharged and non-active and in
19   a filing cabinet that we have in our room

In this data extract, CPN uses what might be termed a 'medico' legal frame to open the account.[4] The client is characterised at the outset as a dangerous person — one who 'shouldn't be seen alone by any women' (L.4). His past history as a resident of Fernley Special Hospital, a Home Office Secure Establishment, is invoked (Ls.5-6). This characterisation is reinforced by CPN's description of the information she received about the client from a staff member at the Metropolis Day Centre — 'pretty strong advice' (L.6). The client's past history of psychiatric care is fleetingly acknowledged (L.12) but immediately relegated to a secondary position in the narrative. This new information about the client does not prompt a change of frame. The potential dangerousness of the client on the other hand is brought into sharp focus and 'worked up'. He is characterised as being 'a very dodgy character to have around women' (L.15). There is a pointed allusion to the client's 'forensic involvement with his girlfriend' (Ls.16-17) but this receives no further elaboration. He is a 'bad client' in Jeffery's terms as he breaks the rule which expects patients/clients to cooperate with 'competent agencies' in the treatment process (1979:94). The client's characterisation as 'dangerous person' creates a trouble in the talk as his actions are constituted as conventional/theoretic. He is 'heard' as being responsible for his actions which are *not* mitigated by the presence of current mental illness. Arguments to counter this view are

4 Pfohl's study identifies the use of framing which organises what he calls 'assumptions about relevant clinical-legal categories'. Such framing delimits the 'form of final diagnostic decisions' (1978:119). Such diagnostic decisions are functional to the maximum security setting studied by Pfohl where the clinical diagnosis of the patient also has legal implications. Frame use in the MHT study is broader and more flexible; the client context is not one generally described in terms of criminality.

not possible in this context as the CPN only has access to that part of the client's history which suggests that he is dangerous.

It appears from the CPN's description that the team's usual 'frame(s) of interpretation' have been severely challenged (Tannen and Wallat 1987:206). A possible client has been constituted as conventional/theoretic which offers little scope for the team to practice its chosen skills. Confronted by this direct and graphic description of a very dangerous person, team members have difficulty operating within this unfamiliar frame. The upshot of this is a change of frame to the bureaucratic (Extract 6:5, below) where discussion about the client changes to discussion about his notes:

Extract 6:5

20 G: This is CPN2's auditing — follow up

21 DR: So the notes were

22 CPN2: Sorry?

23 DR: So the notes from Fernley

➜ 24 CPN2: Well, I'm going to follow them up because they wouldn't give them to the Metropolis Day
25   Centre [pause]. There's an RMN[5] there but they — they, wouldn't, even though he's been
26   there for ten years

27 G: I think they — they will send it to [name of Dr]

In the extract above, CPN2's utterance on L.24 might be seen as an attempt to laminate the bureaucratic frame with the clinical with the new information that she is going to follow up the client's notes. This brief attempt to establish a clinical frame is untenable however as the secure hospital has refused to pass on further information to the day centre. A colleague, G, takes the next turn of talk attempting to keep within the fragile clinical frame promoted by CPN2. He suggests that Fernley might send the client's case notes to the team's consultant psychiatrist (L.27). But the laminated bureaucratic/clinical frame proves inadequate to deal with the case of a conventional/

[5] Registered Mental Nurse.

theoretic client who has not been characterised in purely illness terms. Like Peräkylä's exploration of framing devices in the context of the terminally ill, *this* trouble in the talk for the MHT can be viewed as a 'deviation' which causes:

> *'a threat to the working conditions and/or the moral order of the ward'* (1989:123)

— or in this case, to the team. In the MHT setting it is the emergence of an inappropriate situation which creates the 'trouble' as it has the potential to sabotage members' accustomed role as practitioners of mental health care. In Peräkylä's research, the 'threat' to ward order is managed through a shift into the psychological frame. Here the 'trouble' is managed through a shift into the ethical frame so that discussion around the client becomes discussion around the nature of psychiatric care itself. I will be dealing with issues of theoreticity and framing in succeeding cases too, but at the moment, I will concentrate on the case at hand. Following the change of frame to the ethical, the focus of the account now hinges on the issue of confidentiality and informed consent (ie. for the release of case notes) and is embodied in the utterance made by R in Extract 6:6, below:

Extract 6:6

```
28  R:    I'm not happy with that. I have to say that I'm not happy with that 'cos I don't think that
29        that's [pause] — the client is not a client of this service — not using this service. I think if
30        he does come to you for service, then that's fair enough, but otherwise, I don't see why we
31        actually need to see those notes
```

A long debate ensues, with R and the team doctor being the main protagonists. Client confidentiality on a 'need to know' basis is the essence of the debate with temporary resolution being reached in the laminated ethical/bureaucratic frame in Extract 6:7 which follows:

Extract 6:7

```
98   CPNC:  I mean, one thing is, the responsibility for releasing this information lies with Fernley;
99          they send the information out about permission — that's their — in a way, that's their
100         thing isn't it. They put that information [out]

101  DR:    Well — let's look — let's — if we play safe on confidentially — confident, confidentiality
102         issue — till we actually make contact, the worst that can happen is that two of us will
103         go and do an assessment, rather than one, and can wait for the notes. And I think that's
104         reasonable

105  R:     I mean, I think — notes can be done quite quickly [    ] I mean, I think if you go into
106         that kind of situation knowing that you'll be seeing a potentially dangerous person — then
107         you prepare yourself regardless of whether you've got the notes or not, really [pause]. I
108         mean, most of the people we see, often with past psychiatric histories — we don't have
109         notes on them at all. We don't know — what we're dealing with so we're operat — we
110         should be operating on the idea that there's always the possibility that, you know. One of
111         the things we're doing is assessing and things like that — and so on and so forth. I mean,
112         it's an issue around confidentiality
```

Resolution is *not* reached at this stage however as a further 'trouble' is created by the doctor's utterance on L.113, Extract 6:8, which follows next:

Extract 6:8

```
113  DR:    I must admit, I'm not really convinced [    ]
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An episode of team laughter is the upshot of the doctor's utterance (L.114, not shown). One can only speculate as to the function of this episode of laughter. Rostila for example might see it as serving an 'affiliative' function in 'programmatic action' (1992:12). Certainly it marks the end of a very lengthy ethical debate about confidentiality which does not result in team consensus. It also marks a change of frame to the purely bureaucratic following the 'trouble' created by the doctor's utterance on L.113 in the previous extract. J, a CPN, takes the turn made available by team laughter and frames her utterance in bureaucratic terms:

Extract 6:9

```
115  J:     What about when you think somebody's heading for a section — when you think they're
116         sectionable? 'Cos that happened to me a little while back at [name of home] — and I
117         knew she'd been in touch with St. Hilda's recently, and I did try and talk to her about
118         notes but she just wasn't in touch with anything I was saying at all
```

As Peräkylä observes, 'the scene is completely re-organised' with a shift of frame (1989:123). The team's deviation from the laminated ethical/bureaucratic frame in this context is legitimated by the overriding need for bureaucratic expediency. The danger posed by the client has prompted a change of frame to the bureaucratic without compromising the team's ethical standards on confidentiality which are crucial to its culture.

I will now summarise how my analysis of frames has helped in understanding how the client is constructed. Members use frames and laminations to frames as a means of managing troubles in the talk. Such troubles include a client defined as theoretic or a threat to the working practices of the team. Inappropriate clients are managed through members' use of the bureaucratic frame which becomes the problem-solving frame in MHT casework. Use of the bureaucratic frame preserves the moral order of MHT practice.

The next section will examine how members construct 'appropriate' and 'inappropriate' clients. MHT data in this section will demonstrate the flexibility of members' use of frames. Frames can provide the team with an analytic base for managing ambiguity (Goffman 1974:307). In this respect, frames are very important as they permit members to produce clients who are appropriate objects of the team's work. Frames also permit the construction of *in*appropriateness. The section will start by examining how 'appropriate' clients are constructed. It will then consider the management of 'inappropriateness' through team use of the bureaucratic frame which is its main problem-solving frame.

6.2 'Appropriate' and 'inappropriate' clients

Clients who are constituted as pre-theoretic are those whose characterisations strongly imply the presence of mental illness in the majority of cases discussed (Dingwall and Murray 1983:135). Such cases are regarded as 'appropriate' in the context of the

team's work as mental illness is 'heard' as a constraining factor in considering the majority of clients' actions. McHugh points out that if an action is considered to be non-conventional from the very beginning — (s)he would be due rehabilitative treatment rather than punishment (1970:172-173). Mentally ill people then, are 'appropriate' clients for the team to engage because they constitute those with whom the team can work. Like doctors working in accident departments who work to 'a rule of clinical priority' (Dingwall and Murray 1983:143) — team members also work to a rule of clinical priority in the context of mental illness. The following extract is of a client who typifies clinical priority. His case is presented by DR, the team's doctor:

Extract 6:10

4 G: You know — I was thinking of the other guy that you mentioned you've been seeing

5 DR: Yeah — I was going to raise him because I'm going to see him with [doctor's name] with
6   a view of sectioning him later this afternoon. Just on the off chance that he disappears
7   from Oakley House and just turns up. His name is [name of client] — an Hungarian guy
8   — um — very very psychotic — um — very thought disordered, full of a lot of delusions
9   about people injecting him with PC's, um. Thinks that the staff in Oakley House know
10   about it. Doesn't yet think that they're actually doing it to him, but he's convinced that
11   everybody else knows what's happening. And so — he gets very irritated with people. He
12   was chucked out of Bellmonts Hostel three times, ah, the last time because he was found
13   to have a hatchet, um

14 CPN2:   He was actually threatening to use it

15 DR: Right, so — again — if this gent turns up anywhere, he would be best seen with some-
16   body else, but I hope we're going to be able to get him in [to hospital]

17   [GENERAL BACKGROUND MURMURING AMONGST ALL TEAM MEMBERS]

18   [Tape, over: off tape, remark made that the client would be best seen "in a full set of
19   armour" — a remark that was greeted by laughter from all]

This client is already well known to the team as he is a resident of one of the local hostels which they periodically visit. His case is offered to team members by the doctor as the client's behaviour and general demeanour has been a cause for concern. The client is characterised in mental illness terms and is thereby constituted as pre-theoretic. The description creates a picture of a highly disturbed client whose actions

are non-conventional using McHugh's notion of deviancy (1970:157). In this situation, the client would not only be seen as not being responsible for his actions, he would also be seen as having no alternative. Given the client's perceived potential for violence — this construction of the client has a particular 'urgency' in terms of clinical priority (cf. the client in Extract 6:4 whose perceived dangerousness is a team priority).

How is this characterisation of a mentally ill client constructed?[6] DR, the narrator, reports that he and a medical colleague are visiting the client later that afternoon 'with a view of sectioning him' (Ls.5-6). This refers to a section of the Mental Health Act (1983) which immediately characterises the client as being mentally ill, and by inference, as not being responsible for his actions.

The initial characterisation of the client is worked up so that the client is described as not just being 'psychotic' but as being 'very very psychotic' (Extract 6:11, L.8). This serves to emphasise the gravity of his mental illness. He is seemingly out of touch with reality being described as 'very thought disordered' (L.8). He is also characterised as being deluded (L.8), believing that unspecified parties are injecting him with substances which could be harmful to his person:

Extract 6:11   (Part of Extract 6:10)

8 DR: — um — very very psychotic — um — very thought disordered, full of a lot of delusions
9   about people injecting him with PC's, um. Thinks that the staff in Oakley House know
10   about it. Doesn't yet think that they're actually doing it to him, but he's convinced that
11   everybody else *knows* what's happening. And so — he gets very irritated with people. He

In the extract above, the client's behaviour is 'heard' as stemming from mental illness: 'And so — he gets very irritated with people' (L.11). This behaviour is offered as 'the reason' for the client being thrown out of his hostel on three separate occasions. What makes the last occasion so concerning for the team is that the client 'was found to have

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[6] In Pfohl's (1978) study, the process of client construction is referred to as 'imputational work' (1978:3).

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a hatchet' (Extract 6:10, L.13). The team's concern is evident from the upshot of DR's characterisation which is a question from CPN2:

Extract 6:12   (Part of Extract 6:10)

14   CPN2:   He was actually threatening to use it

In the next extract, DR takes the next turn of talk confirming the client's potential for violence (Ls.15-16).

Extract 6:13   (Part of Extract 6:10)

15   DR: Right, so — again — if this gent turns up anywhere, he would be best seen with somebody
16   else, but I hope we're going to be able to get him in [to hospital]

The client characterisation which now predominates is that of mentally ill and dangerous person. The frame utilised to manage this characterisation is the practical (see Extract 6:10, Ls.12-16). In the context of the team's work, this characterisation constitutes clinical priority. In Dingwall and Murray's (1983) terms, the client is a Category 'C' client who breaks rules but who is not responsible for his actions, and this leads to 'rehabilitative treatment' (1983:135). Such treatment is described in Extract 6:13, L.16 where DR expresses hope that the client will be admitted to hospital. The additional potential for violence in the context of insanity serves to upgrade the clinical priority and illustrates Prior's observation that:

> *'in the everyday concerns of psychiatrists it is ultimately bodies that*
> *are stabilized rather than social relationships'* (1993:67).

It is interesting to note DR's use of the term 'gent' to describe the client on L.15. Fieldwork and transcription notes indicate that this descriptor is used in only one other account in the study (Tape 3, Case 1, L.8: 'This gentleman Mr Dunton' - see Extract 3:11). In all other accounts, male clients are referred to variously as 'man', 'chap',

'bloke', or 'guy'. In both instances where 'gent' or 'gentleman' is used, the threat of physical violence is the overriding feature of the account. It is possible that members' use of this polite, but exaggerated form of social address functions to alert staff to possible danger in situations where male behaviour towards others is anything but 'gentle'. Emerson et al state that in fieldwork, it is rare to encounter subjects referring specifically to social class (1995:138). That MHT members *do,* if only on two occasions, might indicate that it has a situational relevance.

This exaggerated gentility also has resonances with Dingwall and Murray's (1983) early observations on the use of the bureaucratic 'mode' in the A&E setting. They suggest that this helps the smooth running of a busy department which might otherwise be slowed down by 'moral attacks' and their 'consequent disputes' (1983:136). In *this* study, the MHT's descriptor of a female client who represents an anomaly is that of 'lady' (see Extract 6:49, L.5).

In Extract 6:13 the team's concern with managing the client's physical body becomes the overriding concern. It appears again after the tape is turned over with CPN2's utterance:

Extract 6:14   (Part of Extract 6:15)

20 CPN2:   About this business with the hatchet

It is entirely appropriate that the team intervenes in this client's case. He is characterised as 'sectionable' which immediately establishes the clinical priority. This characterisation is compounded by the additional description of potential for violence. The client is constructed as having a serious mental condition necessitating the intervention of not one but *two* different doctors. Like the medics in Dingwall and Murray's accident departments, the clinical condition of clients has to be established quickly 'if the department's practice is to be defensible' (1983:143-4). In terms of the

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work of the MHT, members' practice would certainly *not* be defensible if the situation of an acutely ill and highly disturbed client were not addressed immediately. This deluded client in possession of a hatchet then, is in every way an 'appropriate' client for the team to accept.

The narrative is conducted in the clinical frame in the main (Extract 6:10, Ls.4-11) and then changes to the practical (Ls.12-16). However, these are not workable frames for the remainder of the account (from side 2 onwards) as they fail to deal with the subject of potential violence — violence that is seen as being 'over and above' that normally encountered by the team. This is why frames are important. They can be changed to serve different functions. CPN2's utterance about the hatchet (Extract 6:15, L.20) heralds a trouble in the talk which initiates a new frame. This new frame is the bureaucratic. The episode of general laughter as the tape is turned over marks the change of frame, and it is within this new frame that the appropriateness of taking on this seemingly appropriate client without alerting other teams to possible danger, is debated. Part of this account is given below:

Extract 6:15

20 CPN2: About this business with the hatchet

21 G: I suppose — going back a bit to [name of client's] case. I mean — say, for example,
22   should we see someone like that — should we alert other teams?

23 CPN2: Well — I knew that/I rang around places — Bellmonts Hostel, and um [   ]. At his last
24   admission, he got chucked out of Bellmonts Hostel twice and was allowed back the third
25   time on the proviso that he would see the Mental Health Team. And I rang [Hostel staff
26   member] and she immediately said: Very dangerous man; be very careful. Never see him
27   alone

28 Y: The other thing on that issue I think is if it's somebody we've seen very recently and we
29   really think is a risk, then I think that's fine. But I think the thing about [client's name] is
30   different, is that he hasn't been seen for about nine months

31 G: You haven't seen [   ] — he was alerted

32 Y: Yes — he was out quite a long time. I mean this guy — this guy's actively [disturbed]

33 G: No, I just mean, as a matter of formality — of routine — should we be [pause] — linking
34   with the other three teams? You know — if you see somebody like him/we pick up, and
35   then, if he disappears, should we let the other three teams know as a matter of routine or
36   not?

37 CPN2:   That's — very time consuming

38 R: And I think — and I don't think we should make any strict rules about 'routine' on things
39   like that. These things need to be dealt with on an individual basis — a lot — I mean —
40   there need to be basic rules, basic policies about the way we deal with confidentiality. But
41   in circumstances like that, you're looking at — you need to think like, you know: Is he
42   *known* to have been seen in other areas? Does he/is there any history of him using any
43   other centres and, if so — is he likely to go — or, if so, is he likely to go — is he likely to
44   come to the attention — I mean, if he brains someone with an axe — chances are, he's
45   going to come to somebody's attention

46   [GENERAL LAUGHTER]

47 CPN2:   If there's an axe — yeah

Clients constructed as a clinical priority are appropriate for the team to consider as their case fits MHT concerns and its philosophy of care. But cases that do *not* fulfil the clinical grounds for team engagement are also debated by the team. Under such circumstances the team's decision-making takes a slightly different form which serves to accommodate the inappropriateness of the case. A demonstration of how team members 'manage' working with inappropriate cases is given in Extracts 6:16 to 6:48, all of which come from the same case.

The client in question is a primary drug user who is in danger of losing her hostel place if her drug use becomes known to the hostel staff. The case is not typical of MHT work generally as illicit drug use is regarded as a lifestyle choice. The possibility of becoming involved in the client's case requires a 'creative' solution — one which works in the best interests of the client on the one hand but which also protects the integrity of the MHT on the other. The outcome of the team's deliberations is to make the client's residence, Latimer Street Hostel — 'the client'. Shifting into the bureaucratic frame is the team's eventual solution for managing the trouble of client inappropriateness (see Extracts 6:46 to 6:48). However, data suggest that frame

changes occur *throughout* the account as troubles arise in the talk. This is demonstrated in Extracts 6:32, 6:36 and 6:43 where members draw on a range of different frames to manage threats to the client's pre-theoreticity or to the working practices of the team. These will be discussed later in this chapter.

In Extract 6:16 members' talk reaches a point where the team rule about *not* engaging drug using clients is heard as 'constraining' in terms of the client's need to maintain settled accommodation. This part of the case is conducted in the clinical frame:

Extract 6:16

31	CPNC:	When I saw her, it became apparent quite quickly [laughing] that she was a primary drug
32		user and I thought she was probably into lots of things before I saw her [ ] and that was
33		why she was so [manic]. She was on quite a lot of Methadone, although she denies that
34		[ ]. Um — she has a long history of homelessness. Um, she's had/usually after the
35		break up of relationships, and she's lived in — um — a women's hostel in Troughton.
36		She's lived on the street quite a lot. For the last three years she's lived on and off in the
➔ 37		Terrace Place [area], Kiley. Um, she's had what she describes as extremely violent
➔ 38		relationships with men, um, and [ ]. She's been badly injured by them. Her father is, um,
39		a charge nurse at a hospital in Colville, um — Psychiatric Charge Nurse. She's had some,
40		um, dealings with Psychiatric services but seems to me it's always been after deliberate
➔ 41		self harm, and she's always been discharged because they say — it's not for mental illness.
➔ 42		I couldn't elicit from her any, um, evidence of mental illness at all. And she — it
43		transpired that once — she admitted to having a drug problem — that she's actually very
44		well engaged with the drug services at the Abstinence Hospital [ ]. She's also got a
45		very long forensic history and has had five custodial convictions in Metropolis Prison for
46		things like eating sandwiches in N & M — sort of, well known to them. But she was
47		actually on a semi-sentence when she went in there — nicked a sandwich and ate it in the
48		shop. Um, got two or three days for that. She did things like throwing things through hotel
49		windows, um — but mainly, theft and burglary. So, um, I felt that she — she wasn't
50		somebody who was appropriate for our team to be involved in. Problem is, she doesn't
51		want the hostel to know she's got a drug problem.

Talking about the client's convictions in the clinical frame constructs them as 'features' of possible illness. Her subsequent behaviour is 'heard' as stemming from her characterisation as mentally ill (L.40). In this respect CPNC's description of the client exemplifies the behaviourist discourse which 'reduces' the client to an amalgam of behavioural traits (cf. Prior 1989:138). The client's behaviour is constituted in terms of:

- damage to property ('throwing things through hotel windows,' Ls. 48-49)

- indulgence in theft and burglary ('nicked a sandwich', L.47; 'theft and burglary', L.49).

The problem of the client's behaviour is a difficulty for the team as it sometimes leads to criminal conviction. Without the mitigation of mental illness such behaviour would normally preclude the client's engagement by the team. Extract 6:16, Lines 41 and 42 demonstrate CPNC's renewed 'search' for mental illness. This demonstration is not conclusive. In the extract which follows, the upshot of CPNC's characterisation is her voicing of the inappropriateness of the client's case:

Extract 6:17   (Part of Extract 6:16)

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49  CPNC:  ............................................................ So, um, I felt that she — she wasn't
50              somebody who was appropriate for our team to be involved in.
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CPNC's construction of the inappropriateness of the case is further compounded by her additional utterance stating that the client does not want the hostel staff to know 'she's got a drug problem' (Extract 6:18, L.51). This constitutes a 'trouble' in the talk as CPNC's construction of the case infers that team intervention is not appropriate. CPNC manages this trouble by drawing attention to the client's self-damaging tendencies:

Extract 6:18   (Part of Extract 6:19)

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51  CPNC:  want the hostel to know she's got a drug problem. And — she's also got these sort of —
→ 52             deliberate self harm [tendencies] — I think she'll be likely, um, to continue, particularly if
53             she's using alcohol as an anxiolytic, I think, while they're reducing the Valium from the
54             Abstinence Hospital. So I think that she's quite likely to start harming herself, or other
55             people, and that the Latimer Street people are likely to contact us again later. And I feel
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CPNC describes the client in terms of her 'deliberate self harm' (Extract 6:18 above, L.52) and her history of 'violent relationships with men' (Extract 6:16, Ls.37-38).

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However, this description of the client does not constitute mental illness in itself. What CPNC accomplishes with this description is a focusing of attention on the *outcome* of the client's behaviour ie. physical hurt, rather than on the behaviour itself. The formulation of this new description of the client is an interesting one as it defines the client's actions as pre-theoretic. It is also problematic as L.51 (Extract 6:19, below) constitutes the client as a drug user — 'she's got a drug problem'. But linked to this description of the client is an alternative description of the client ie. one who has 'deliberate self harm tendencies' (L.52). It is the second of these two descriptions which is privileged over the first in the ensuing team discussion. The work that it does is to reconstitute the client as someone with whom the team can work ie. someone who is mentally ill. The upshot of this medicalization of the client's behaviour is a demonstration of the rule of advocacy:

Extract 6:19

51 CPNC: want the hostel to know she's got a drug problem. And — she's also got these sort of —
52 deliberate self harm [tendencies] — I think she'll be likely, um, to continue, particularly if
53 she's using alcohol as an anxiolytic, I think, while they're reducing the Valium from the
54 Abstinence Hospital. So I think that she's quite likely to start harming herself, or other
55 people, and that the Latimer Street people are likely to contact us again later. And I feel
56 — I can't say to them: I'm not going to be involved with her, or not getting involved with
57 her because she has got a primary drug problem, and that she's well engaged with the
58 Abstinence Hospital — she says, she's well engaged with the Abstinence Hospital. So I
59 [long pause] — I think that's quite a difficult situation for us

The client's behaviour is converted into the psychiatric diagnosis of 'anxiety' which she is *in*appropriately self-treating with alcohol (Extract 6:20 below, L.53). Moreover, this period of inappropriate self-medication is likely to continue whilst the client's 'prescribed' medication is being reduced at the Abstinence Hospital:

Extract 6:20   (Part of Extract 6:19)

53 CPNC: she's using alcohol as an anxiolytic, I think, while they're reducing the Valium from the
54 Abstinence Hospital.

131

CPNC does not leave the possible consequences of allowing the client to continue in this way — to chance. Ls. 54-55 (below) might be heard as a summary of the whole case:

Extract 6:21   (Part of Extract 6:19)

54 CPNC: Abstinence Hospital. So I think that she's quite likely to start harming herself, or other
55   people, and that the Latimer Street people are likely to contact us again later. And I feel

It also endorses and exemplifies the team's philosophy of care which is to support individuals who are mentally ill and who are vulnerable to homelessness. CPNC's new information changes the client definition to conventional/pre-theoretic:

- she is 'heard' as suffering from self harm (Extract 6:19, L.52), violent relationships (Extract 6:16, Ls.37-38) and from anxiety — a definable and treatable psychiatric condition (Extract 6:20, L.53)

- she is 'heard' as having no access to help for this condition because the Abstinence Hospital are reducing her medication (Extract 6:20, Ls.53-54)

- the result of this untreated condition is that the client might harm herself (Extract 6:21, L.54) — vocabulary very reminiscent of the Mental Health Act.

Interestingly, there is no mention of 'deliberate' in this description of harm unlike earlier descriptions of the client's behaviour which have served to downgrade her eligibility to receive psychiatric support. On one occasion the client reported that she had been attacked by a man in a public house. She had a 'deep laceration to her forehead' (L.11, not shown) and this had required sutures. After police questioning, it transpired that the wound had been self-inflicted:

Extract 6:22

15 CPNC: — the Police, in fact [found] she'd done it herself. There'd been a couple of witnesses in
16   the pub and they'd seen her. Nobody had done it to her. That was one

On another occasion, the client flung her arm through the window section of a door almost severing an artery in her wrist. Again - this action was constituted as deliberate. CPNC saw the client on this occasion and saw no 'evidence of real (psychiatric) disturbance' (Ls. 19-20, not shown). However, in Extract 6:23, CPNC's 'updated' description of the client invokes her dealings with psychiatric services in the past:

Extract 6:23   **(Part of Extract 6:16)**

39 CPNC: charge nurse at a hospital in Colville, um — psychiatric charge nurse. She's had some,
40   um, dealings with Psychiatric services but seems to me it's always been after deliberate
41   self-harm, and she's always been discharged because they say — it's not for mental illness.
42   I couldn't elicit from her any, um, evidence of mental illness at all. And she — it

This *new* description 'strengthens' the client's pre-theoreticity. She is characterised as being vulnerable in terms of self-harm due to the possible consequences of her anxiety:

Table 6.1: Category 'C' definition

	CONVENTIONAL
PRE-THEORETIC	C. Breaks rules Not responsible

From: Dingwall, R. and Murray, T. (1983:135).

Such behaviour might cause difficulties for the hostel staff so that the eviction of the client becomes a possibility. But this same client is also a user of illicit drugs which poses a huge dilemma for the working practice of the team:

133

Extract 6:24   (Part of Extract 6:19)

58 CPNC: Abstinence Hospital — she says, she's well engaged with the Abstinence Hospital. So I
59   [long pause] — I think that's quite a difficult situation for us

The dilemma (L.59, above) is managed by reinvoking an earlier characterisation of the client:

Extract 6:25

60 G: Are you sure she hasn't got Carcinoma?

G's utterance in the previous extract serves to provide the grounds for a short, single turn sequence of talk involving himself and CPNC:

Extract 6:26

61 CPNC: Well — she *has* got Carcinoma

62 G: She has

63 CPNC: Yes but she's

64 G: As well

65 CPNC: That's been treated by the gynaecologist

66 G: I thought that was just a, just a 'story' which she

67 CPNC: No — that's actually true. That's been treated [   ]

68 G: Oh

The source of G's knowledge, such as it is, comes from CPNC's earlier description of the client where she states that the client has an 'invasive carcinoma of the cervix' (Ls.27-28, not shown). G's questions to CPNC might be read as an invitation to CPNC to provide an 'authoritative version' of the client's physical health (Bergmann 1992:142). But just when it appears that the vulnerability of the client has been established beyond question, Y creates a fresh trouble in the talk with her challenge to the use of Methadone as a means of controlling pain:

Extract 6:27

69 Y: But she says she's on Methadone for the treatment for

Y's utterance on L.69 (above) potentially undermines the whole 'construct' of the client as ill. Its upshot is a shift of frame from the clinical to the ethical frame. In Extract 6:28 which follows, the onus for telling the hostel staff about the drug use is put firmly into the hands of the client with advocacy being the 'pay off' for the client if she agrees to do as the team suggests:

Extract 6:28

70 CPNC: She told the hostel that — that's not what/well I know that's not what

71 Y: Hm. Could you say, um [long pause] — I'm — no. I mean — if the drug issue is why
72   you're not going to see her, then could you not say to them [muffled]: I'm not going to be
73   able to tell you about that; you'll have to talk to her about that — so that she knows why.
74   Put it back to her; put it back to her to actually tell the staff why. Do you think that would
75   satisfy them?

76 CPNC: Um

77 Y: No — if you actually wrote to her and said — you know — you said: I've written to her
78   and said — this is why I can't see you — she has that letter; she knows

79 G: Hm, hm

80 Y: It's up to her to tell them why

81 CPNC: Well, I have arranged to see her once more to tell her what the outcome of the session
82   was so I think [   ]

83 G: Right

But the ethical consideration of illicit drug use does not appear to be the most important issue to the CPN. In Extract 6:29 (over page) she invokes the typicality of this phenomenon in the hostel environment and appeals to team knowledge of 'custom and practice' regarding transactions made between hostel staff and drug using clients:

Extract 6:29

86 CPNC: and telling them that, you know — that. She *may* think they're not happy for her to live
87 there if she's got this problem. I don't think/they probably would think it was alright 'cos
88 they've got other people there. It's not — it's not that. The other thing is whether people

Like the knowledgeable readers of clinic records described by Garfinkel (1992:201) CPNC demonstrates her knowledge of the informal contracts of hostel work which deny places to drug users in theory but which accommodate them in practice. The predominant issue for CPNC is not so much the *client's* morality but the morality of taking any decision which involves the team in casework with the users of illicit drugs:

Extract 6:30

88 CPNC: they've got other people there. It's not — it's not that. The other thing is whether people
89 think it's alright to link with somebody involved like that

In the extract above, CPNC's utterance is a reformulation of the primary dilemma for the team's work which occurred earlier in the account:

Extract 6:31

4 CPNC: and currently, has had a termination of pregnancy. I really want to discuss — not that
5 she's particularly, um [   ] or difficult — but I think because it really presents some
6 questions about, uh, us working with people who present these sorts of problems and, uh, I
7 just wanted to see what people thought about [   ]. She came into Latimer Street Hostel

However, the overriding dilemma of inappropriateness still has to be resolved. It constitutes a trouble in the talk which is marked by a shift of frame to the bureaucratic. Within this new frame, Y makes an appeal to the rules:

Extract 6:32

90 Y: I suppose — do we bend the rules slightly because of the relationship we have with that
91 particular — you know — it's almost like we're the Consultant almost — or are we? I don't
92 know. S'pose in the past, we have worked like that haven't we?

Y's utterance demonstrates Silverman and Jones' (1976) premise that:

'members provide for the rationality of their projects by displaying the rule-governed character of their proceedings . . .' (1976:161).

This inappropriate client constitutes a problematic case for the team's terms of engagement. The upshot of CPNC's question: 'whether people think it's alright to link with somebody involved like that' (Extract 6:30, Ls. 88-89) is Y's taking of the next turn with an appeal to the rules (refer to Extract 6:32, L.90).

In the case of Silverman's 'anomalous' interview candidate, ex post facto grounds are provided by the selectors so that the rational character of the decision is not compromised (1976:161). In the case of the MHT's inappropriate client (Extract 6:32), Y suggests:

- a *bending* of the rules because of the team's perceived (special) 'relationship' with the hostel staff (L.90)
- the temporary transfer of the (absent) consultant's decision-making powers to other team members (L.91).

Her utterance is upgraded by invoking the rule of 'custom and practice': 'S'pose in the past, we *have* worked like that haven't we?' (Extract 6:32, L.92). Y's appeal to a 'bending of the rules' demonstrates Garfinkel's notion of 'ad hocing' (1992:21). CPNC takes the next turn of talk providing a continuer:

Extract 6:33

93 CPNC: Hm

This allows Y to take a turn in which she gives adequate grounds for 'bending the rules'.

Extract 6:34

94 Y: That — that — we're the only support agency that they're in contact with for people that
95   they have problems with

96 CPNC: Yeah

97 Y: Do we then have a 'special relationship' with them whereby we, you know, we might
98   say: Well — look, I can't work with her but I feel I *am* able, with her permission, to support
99   you

100 CPNC: Yeah [pause], or even to support *her* on some level, but I can't get involved with. This is
➜ 101   what/the problem which she had earlier with oral substances. This is not, this is not
102   appropriate for me to get [involved]

103 G: I mean — would she be amenable to [name of service] as a back up as well — as part of
104   the Team?

The sequence above is a demonstration of the team's endeavour to make a policy decision about an inappropriate client in the absence of its consultant. For all practical purposes, it both represents and is representative of, members' deliberations on the bending of the rules. The upshot of these deliberations is the unfeasibility of applying the 'new' rule in practice. CPNC accounts for this in terms of the client's propensity to 'move on' having used oral substances in the past (L.101). This new knowledge constitutes a trouble in the talk which is marked by a shift of frame to the practical:

Extract 6:35

110 G: I suppose in a way you know — from what I know of Latimer Street, they will have
111   someone there to stay if they're abusing drugs, but it's not so much about the abuse of
112   drugs — it's about the consequences of behaviour that is going to lead to her — er —
113   conviction

Like CPNC earlier on in the transcript (Extract 6:21, L.54: 'she's quite likely to start harming herself') — G invokes the possible consequences of the client's behaviour rather than her abuse of drugs (Extract 6:35). In *this* instance, however, it does not serve to constitute the client as vulnerable in terms of mental health. It functions to construct the client as vulnerable in terms of her behaviour. The consequences of the

client's behaviour might lead to criminal conviction. G's utterance then, may be seen as a form of 'character work' which is concerned with the client's 'future behaviour' (Strong 1979:42). The upshot of G's character work is indictment of the likely consequences of the client's behaviour ('conviction', Extract 6:35, Ls. 112-113) which is marked by a hesitation — 'er' (L.112). This resembles the marking of 'delicate issues' in sexual counselling work (Silverman and Peräkylä 1990). In *this* context it provides an opening for team members to debate the implications of trying to work with an inappropriate client.

Client inappropriateness remains a continuing trouble in the talk. On this occasion it is managed by a shift of frame to the practical:

Extract 6:36

114 Y: What would they do about that anyway?

115 CPNC: Well — nothing. They might point out to her if she [   ]

116 G: That's right

117 CPNC: She's going to be thrown out

118 Y: Which is what they could do anyway

119 G: That's right

120 CPNC: Yeah — and they *will* do. They've given her a warning, so if she does it again

The previous sequence functions as an authoritative endorsement of what the team already knows about inappropriate clients. Y takes the next turn of talk:

Extract 6:37

121 Y: So — in a way — actually we can't do anything anymore than we're already doing

Her utterance on L.121 (above) represents the authorised summary of the team's interpretation of the case.

139

Later in the account, this summary is scrutinized for its practical utility:

Extract 6:38

126 OT: Can I ask you a question about crisis intervention?

CPNC takes the next available turn (L.127). She provides a new interpretation of the client's behaviour which is typical of cases categorised as psychiatrically or situationally urgent:

Extract 6:39

127 CPNC: That — well that's the other thing because if Latimer Street feel like she's 'acting out', or
128   they — I mean — they quite often ring up and say what's — to do — whether we —
129   respond — to — that. The likelihood is because even though [   ] it's quite likely
130   something will happen that day, or will happen while we're there

On L.127 in the extract above CPNC refers to 'acting out' behaviour which is descriptive of behaviour associated with some commonly encountered psychiatric/ psychological conditions. This 'medicalizes' the client's behaviour and legitimates team intervention in the case if contacted for advice and support by the hostel staff. It also redefines the client as pre-theoretic so that she is seen as 'breaking rules — but not responsible' (Dingwall and Murray 1983:135). Category 'C' definition 'leads to rehabilitative efforts' (1983:135). This changes the whole context of the client's status and opens up the possibility of 'legitimate' team intervention with an inappropriate client:

Extract 6:40

131 Y: I s'pose sort of, I'd feel that in that context it's appropriate to advise them — perhaps not
132   to actually/you might say to them: Well — what I can definitely do is treat them like anyone
133   who has a problem

Y endorses CPNC's new formulation of the case 'downgrading' the inappropriateness of direct client care by 'upgrading' the appropriateness of indirect care (Extract 6:40, L.131). In effect, this makes the hostel staff - 'the client'. Y's redefinition of the client

as 'anyone who has a problem' (Ls. 132-3) is 'heard' as 'psychiatric problem' by other members of the team. Y's utterance 'works' to reconstitute illicit drug use as 'psychiatric problem' entitling the client to the same duty of care as 'anyone who has a problem'. Redefinition of the client in illness terms is successfully accomplished through a change of context from a background of drug abuse to one of crisis intervention. This redefinition of the case grounds in terms of appropriateness also redefines the team members illustrating Silverman and Jones' premise that:

> 'only in and through members' practices is 'deviance' recognized' (1976:20).

Later on in the account Y questions the *nature* of the team's involvement in this case:

Extract 6:41

141 Y: But, it seems to me it might, from what I'm saying — our liaison in that situation — is
142   that agency 'casual', or do we do *more* for them?

G takes the next turn of talk and provides another perspective on the newly constructed formulation of 'working with inappropriate clients':

Extract 6:42

143 G: No — uh — I remember what I was thinking now, is when you see her next week — I
144   just wonder whether one line to take — for you to sort of say, you know: It seems like you
145   had crisis with drug abuse in the past — and — if you feel that you — you can't deal with
146   that crisis, you have to say to her — when that crisis occurs, they might contact me. I
147   think you have to be quite straight with it in a sense — they might contact me, I think —
148   because you kindly gave me permission to do that — to give, you know, to give the
149   information — then it's going to be at your loss

In Extract 6:42, G demonstrates how team members go about their interpretive work to assemble settings 'which reproduce an organizational structure' (Silverman and Jones 1976:20). This 'organizational structure' which G invokes here is that of a care

team which manages mental illness (refer to Chapter Eight). According to G's formulation of the case, MHT intervention can legitimately occur if the client agrees to let the CPN give information about her drug using to the hostel staff. The client is still defined in pre-theoretic terms — a 'vulnerable person' who has not dealt successfully with crisis in the past and who might well require help in the future. CPNC provides a continuer: 'Hm' (L.150, not shown). G takes the next turn demonstrating the fragility of his own proposal:

Extract 6:43

151 G: Cos, you know, they might have to throw her out, whatever. But if you come straight and
152   come to them and say: I'm also under the care of the hospital, or whatever — at least, if
153   there *was* a crisis, they could ring — the hospital. And that's another avenue we could
154   explore, I don't know

In the extract above, L.151 constitutes a trouble in the talk as it challenges the pre-theoreticity of the client. This is managed by a reinforcement of the existing clinical frame (see Extract 6:16). This re-emphasises the client's pre-theoretic status. G does some additional 'face work' which serves to redefine the client's behaviour, yet again, in terms of 'crisis' (cf. Strong 1979:42). The 'new' description of the client which he invokes is of one who is 'also under the care of the hospital' (Extract 6:43, L.152). The laminated clinical/bureaucratic frame serves to smooth the immediate trouble in the talk as it re-emphasises the client's vulnerability in terms of her physical health. It also creates a possible solution to the team's dilemma about working with inappropriate clients. CPNC takes the next turn:

Extract 6:44

155 CPNC: No — that's — that's good actually 'cos they could do that

G provides a continuer: 'Hm' (L.156, not shown) and CPNC takes the next turn which denotes a shift of frame to the practical:

Extract 6:45

157 CPNC: They won't mind [if] they think she's going for something for Cancer [pause]. You know
➔ 158 — bring up the gynaecologist

159 OT: Yeah

160 CPNC: That's — that's helpful

161 [LONG PAUSE]

162 G: Interesting

In Extract 6:45, various team members support this new formulation of the case but there is still no consensus about how this formulation will actually work in practice. This constitutes a trouble in the talk. The purely bureaucratic frame is utilised as a resource:

Extract 6:46

163 TL: So — what's the outcome of that then?

In the previous extract, TL seeks clarification on how the new role of 'working with inappropriate clients' becomes translated into practice. CPNC takes the next turn:

Extract 6:47

164 CPNC: The outcome — I'm going to see her next week to tell her that I can't be appropriately
165 involved with her — and ask her if she'll — tell the hostel, or give me permission to tell
166 the hostel [   ] and, uh, if she won't, then I'll have to tell her I can't be bothered with
➔ 167 when she's unreasonable [   ] and any crisis will — we'll give them support then [   ]
➔ 168 and that they deal with her in whatever way they feel like they can

169 [PAUSE]

170 TL: Hm. Good plan

171 Y: Hm.

In Extract 6:47, CPNC's action plan (Ls.167-168) provides a solution. It gives the client the opportunity to be seen as a 'good' client (Jeffery 1979:94)

- she can tell the hostel staff about her drug history if she chooses (Extract 6:47, L.165)

- or she can give the CPN permission to tell the hostel staff about her drug history (Extract 6:47, Ls.165-166).

Failure to do so will result in sanctions. 'Sanctions' in this case will be the withdrawal of the CPN's input in care (Extract 6:47, Ls.166-167). She continues by saying that the team will support the hostel staff in the event of 'crisis', but that this support will not be extended directly to the client (Extract 6:47, Ls.167-168).

The 'outcome' rests very much in the hands of the client, but the role of the CPN remains clearly defined as the following extract demonstrates:

Extract 6:48   (Part of Extract 6:47)

164 CPNC: The outcome — I'm going to see her next week to tell her that I can't be appropriately
165   involved with her

This interpretation leaves the way clear for what might be termed 'inappropriate' involvement or 'extraordinary' involvement. Should this occur, it has to occur within clearly defined parameters ie. the client must take the CPN's advice and allow information about her drug using to be given to the hostel staff. Such a solution constructs the client as 'good' because the CPN can continue to practice her chosen speciality (Dingwall and Murray 1983:130). It is also a solution which does not force the CPN to compromise her professional integrity (or that of the team) by breaking client confidentiality. Following McClelland and Sands (1993), this decision illustrates very graphically that in the absence of the consultant:

'team deliberations appear to be a function of who is present and what is negotiated' (1993:74).

6.3 Summary and implications

The length of this case analysis testifies to the difficulty of incorporating the anomalous case into the working practice of a team organisation which does not normally accept clients who are drug dependent. The case is additionally problematic because of the absence of the team doctor on this occasion.

The case demonstrates the team's use of the bureaucratic frame as its main problem-solving frame. This points up a difference with Peräkylä's (1989) analysis of the care of dying patients in a Finnish hospital. In Peräkylä's study, staff draw upon the psychological frame when patients deviate from their expected identities as the objects of practical care. This manages the threat to the working conditions of the ward and to its moral order. The psychological frame also arises spontaneously in staff accounts of their work to the researcher. The dying patient is constituted as an experiencing subject. This 'fits' organisational demands of maintaining order and predictable conditions in the ward.

Apart from the psychological, Peräkylä identifies the use of only three other frames in his study. These are the practical, medical and lay frames(1989:117). This possibly reflects the restricted temporal space of the medical ward setting and its medically restricted care team. In the MHT setting, a much wider range of frames are available to team members (see page 114) — who themselves represent a broader skill mix. The MHT setting is very diverse. It is not bounded by a specific temporal structure in the same way as Peräkylä's ward staff —though it is true to say that its case remit is bounded by a specific geographical catchment area. The team deals with a very diverse client group which is characterised by medical/psychological vulnerability *and* vulnerability in terms of housing. The use of the clinical frame in the MHT setting for example is very flexible — accommodating both physiological and psychological talk, whereas the clinical frame in Peräkylä's study denotes the specifically medical.

Deviation from expected client identity in the medical setting prompts a shift of frame to the psychological. In the MHT setting, threats to a client's pre-theoreticity are primarily managed by a shift to the bureaucratic (see Extracts 6:16 to 6:47). Threats to the working practice of the team are similarly managed. In addition, as Extract 6:47 demonstrates, the absence of the team doctor is a potential threat to the working practice of the team in the sense of the team's decision-making capability. This is also managed through the use of the bureaucratic frame.

6.4 An anomalous case

In Peräkylä's work there are no shifts from the psychological or 'problem-solving' frame to other frames in order to solve problems (1989:124). This is also true of the bureaucratic frame in MHT casework. However, an interesting variation on the use of the bureaucratic frame can be identified in MHT casework as Extracts 6:49 to 6:57 demonstrate. Data refer to an anomalous case. The use of the bureaucratic frame in its own right, and not as a problem-solver for other frames, dispenses with the clinical frame entirely. Clinical talk is peripheral. The totality of what has happened to the client is transposed into the case record. In a sense, the organisational record becomes the encompassing frame (cf. Peräkylä 1989:126).

The subject of the case is housed in bed and breakfast accommodation. She already receives support from a community team other than the MHT. Her mental health status is not clearly defined. The case is presented by G, a CPN. Out of six narratives in this case conference, this case stands apart from the others as it represents a client who is *not* taken on by the MHT. In Extract 6:49, G's opening description of the client is constructed in terms of housing rather than in terms of mental illness.

Extract 6:49

4 G: Can I also very quickly mention someone that I might need some kind of support with
5   really — is — a — basically — a lady was referred by [pause] West Greenton CPN
6   Service down in Moreton; there's a kind of Community Mental Health Team there. And

7	this particular CPN 'phoned me up at the beginning of the year about a woman, thirty
8	years old, who is well known to the service, but for some reason, her housing broke down
9	and she's now in bed and breakfast

The client is from a geographical catchment area which is outside the team's remit.[7] The possibility of client illness is not invoked. Her health status is only partially described and it is left to members to infer what this might be. Extract 6:49, L.8 describes her as someone 'who is well known to the service'. The reason for her housing arrangements breaking down is not postulated as being attributable to a 'constraining factor' such as illness. Following McHugh (1970) the client is constituted as non-conventional/theoretic. Using Dingwall and Murray's (1983) typology, this places the client in Category 'B' ie. breaks rules, responsible/ unavoidable. Debate is conducted in the bureaucratic frame throughout.

As discussed earlier (see p.126), Dingwall and Murray suggest that this bureaucratic mode facilitates the organisational needs of a busy department (1983:136). Similarly with the case under consideration. G's description of the client says very little about her health status, but concentrates on her housing status and the areas of responsibility between care teams. Unlike cases previously cited, this case is conducted in the bureaucratic frame from the outset.

In Extract 6:50, it is reported that a CPN from the West Greenton CPN service has approached the MHT about the client's situation:

Extract 6:50

11	G:	And he sort of, more or less, just said that because she's now in bed and breakfast, our
12		team should deal with it — and I sort of — put him right, you know. I think, that's not on,
13		really, but if you want my help in looking at some other options [ ] and so we left that,
14		um — then Y — Y took a call a couple of days ago from another CPN — from the same
15		Mental Health Service saying that this lady, uh, I think — also referred her to HU
16		[the team's social worker]

| 17 | Y: | Yeah |

---

[7] This constitutes an anomalous case in MHT practice. Barrett (1996) also examines the phenomenon of 'anomaly' in Ridgehaven practice identifying that the 'chronic schizophrenic' is an anomaly. 'Chronic schizophrenics' are not valued positively or negatively (1996:174). According to Barrett, chronic cases are clinically less interesting than others (1996:175).

18 G: And *they* have referred her back — the CPN's there — and they consulted Tony — Prof.
19   Tony George — who suggested that *our* Team should get involved

20   [QUIET LAUGHTER]

21 Y: Yeah, but — how they *put* it to Tony George — depends how they sort of

22 G: But it's interesting that this is a different CPN, so it seems

Correct procedure, rather than the client's health, is the issue central to this sequence of interaction. Y, the team's housing officer, endorses G's account of the case with her utterance 'Yeah' on L.17 (Extract 6:50). G resumes his account (L.18) — the upshot of which is an episode of laughter from other members of the team (L.20). This serves to distance the consultant's remarks which are challenged by Y on L.21. The grounds for indemnifying the consultant's decision are based on his not having the full story regarding the case. This constitutes MHT team members as knowledgeable describers of the case and testifies to their procedural and administrative skills. G takes the next turn. The new knowledge which he contributes functions to provide additional doubt about the appropriateness of members' involvement in the case:

Extract 6:51   (Part of Extract 6:50)

22 G: But it's interesting that this is a different CPN, so it seems

The preceding interaction is heard as 'doing legitimation' for not responding to West Greenton's request and it is validated by the MHT doctor with his taking of the next turn of talk:

Extract 6:52

23 DR: [We] shouldn't get involved with their referrals anyway[8]

In the previous extract, the case is constituted as 'inappropriate' in that agencies in the client's own area are deemed to be the care providers of choice. The client is

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[8] This resembles Byrd's (1981) observation of the 'denial of responsibility' by outpatient therapists. Accounts given by therapists describe staff actions as 'having been required by institutional arrangements' (1981:133).

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constituted as 'trivia' in Dingwall and Murray's (1983) terms because of her inappropriateness. The discussion remains in the bureaucratic frame:

Extract 6:53

28 DR: Why can't the CPN's *and* Greenton Single Homeless Team get involved — *together*?

The doctor's utterance appears to illustrate Dingwall and Murray's observation that although staff complain about trivia:

> *'they seem to act in a way which endorses the open-door policy of the*
>
> *departments and concedes a legitimate area of uncertainty for*
>
> *patients'* (1983:136).

In the following extract, Y's concern is with the amount of extra work which the team will accrue if this anomalous client creates a precedent:

Extract 6:54

31 Y: Basically, what he said to me on the 'phone [   ] at the time — I didn't know she'd
32   already been referred in January, and she'd only been waiting around nine months. But,
33   the issue *really* was/is, well, that um — he was saying: Ah [   ] keeps referring people to
34   us you know, and we can't really deal with all their referrals. I think he was actually hoping
35   we would take her on. That's a whole area of work that we'd

G takes the next turn, maintaining the client's definition as theoretic:

Extract 6:55

36 G: The impression when he first rang me was that — it's actually that they're dealing with
37   her type of thing — mental sort of health, perspective — in that she's — she's *known* to
38   the Service. But because she was in a bed and breakfast, it would take longer to

— and Y reinforces this definition with her utterance:

Extract 6:56

39 Y: Well, he said to me: I don't know why they've referred her to us; we've done a housing
40   assessment. And I said: I can't say I'm worried about her[9]

41   [LOUD LAUGHTER]

42 Y: right — you know [   ] — let's be optimistic, you know. Let's keep the possibility that
43   they're concerned about her mental state and they think she needs assessing

44   [GENERAL LAUGHTER]

Like the doctor on L.28 (Extract 6:53), Y too constructs a cautious description of the client's health status (Ls. 42-43). Such descriptions function to provide an area of diagnostic doubt[10]. They also constitute responsible record making. In Extract 6:57 below, G provides another such description of the client:

Extract 6:57

47 G: thing is really I'm, I'm — the first time round [   ] it might well be that she's known to
48   them and is a bit difficult. She's been in bed and breakfast for nine months now

The next turn is marked by a long pause (L.49 — not shown). The client's health status is unknown. She cannot be constituted as clinically interesting as members can only be party to the description of the client which is made available to them in the account. This is similar to Barrett's (1996) observations at Ridgehaven Hospital. In Ridgehaven's 'back wards', patients with chronic mental illness became of less interest to staff because they had nothing new to offer staff in a clinical sense (1996:175). Unlike the majority of cases discussed by the MHT, the clinical frame has not been utilised in this discussion. It is an anomalous case and as such, it receives bureaucratic treatment (Dingwall and Murray 1983:136). The bureaucratic frame is used throughout.

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[9] Barrett (1996) states that people with schizophrenia are anomalous. Staff tend to patronize such patients or to treat them as mildly amusing (1996:175), as Y does on L.40 of Extract 6:56 in the case of a non-catchment area client.
[10] Atkinson (1995) examines 'the expression of opinion, and the rhetorics of relative certainty' in haematology work (1995:117). Also see Pfohl (1978:219) - 'each contingent feature contains a certain vagueness'.

6.5 Conclusions

Overall, this chapter and the previous chapter have examined how clients are constructed in MHT casework. The team's decision-making processes construct the client as vulnerable in terms of mental health and/or homelessness. Occasionally, clients are constructed in terms of physical ill health as Extract 5:18 demonstrates. A charge of deviancy is brought and then debated (McHugh 1970). Data analysis demonstrates how frames are used and laminated by the team (Goffman 1974). Frames are important as they organise both meaning and team involvement. Reconstitutings in members' talk thus have practical consequences.[11] Following Gubrium (1989) local cultural frames are utilised by members because of their relevance for particular contingencies in case work. This is specifically demonstrated in the team's management of an anomalous case in which the bureaucratic frame becomes the main problem-solver (Extract 6:49).

Analysis of MHT data thus far suggests that members' local enactment of case accounts is gender neutral. However, examining the fine detail of the team's social practices reveals subtle differences in the representation of male and female cases. In the chapter which follows, I will examine how members use gender as an interpretive framework.

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[11] Pfohl states that 'imputational work' has 'social and political consequences' (1978:3).

Chapter Seven: Gender as an Interpretive Framework

Although the local enactment of context has been explored to some extent in Chapter Three, there has been no specific focus on gender so far in this study. Data overall suggest that participants' local enactment of the case context is gender neutral. However, 'paying closer attention' to the interactional detail of this enactment reveals fine differences in the way that male and female cases are constituted (cf. Silverman and Gubrium 1994:179). In *this* chapter, consideration will be given to gender as 'constructed' rather than to gender as 'given'.

Holstein observes that care workers produce descriptions of their clients in the course of their everyday talk and interaction (1992:23). Actions arising from such descriptions have practical consequences in the 'interactional' contexts in which they are produced (1992:25). Gender is pertinent in such descriptions because it displays:

> *'how being male or female is specifically relevant to the case at hand'*
> (1992:29).

In Byrd's (1981) psychiatric outpatient study, the strongest variable is the relationship between gender and presenting complaint. She states that 'the largest percentage differences between females and males lay in the categories "interpersonal difficulties" and "homicidal-suicidal tendencies" . . .' (1981:84).

How do gendered descriptions relate to casework in the Mental Health Team context? Firstly, they organise psychiatric diagnoses in casework talk. Clients' life experiences and behaviour for example are constructed within a 'framework of gender depictions' (Holstein 1992:29). Secondly, they influence social perceptions of the client. In this sense, client descriptions serve to justify particular social interventions which are located in MHT casework and disposal. The documentary method of interpretation is utilised but it is done in a gendered way. What counts as 'appearance' or what counts as 'reality', differs — according to how gender is represented. I will now analyse this phenomenon in more detail.

7.1 The caring role in female client descriptions

Female client descriptions support an early observation by Chodorow that women's lives have a tendency to be represented in terms of social relationships and interaction to a greater extent than men's (1974:57). In addition, the female gender role is socially constructed around the traditional role of caring. More recent work by Waller (1996) on alcohol narratives points to the display of moral adequacy in client accounts.[1] This is particularly marked in female cases. Whereas *all* accounts are moral — what *counts* as moral adequacy seems to be different in male and female cases. The MHT's accounts of female cases supports Chodorow's and Waller's observations. Some concern with family and social relationships is demonstrated in all cases irrespective of gender (cf. Prior 1993:22). However, there are different attributions to different circumstances in male and female cases[2].

A total of forty-five case accounts were tape recorded for the MHT study. Thirty-two of these were of male clients and twelve of female. In addition, there was also one transsexual case account. Family history was invoked in only nine out of the thirty-two male cases:

Table 7.1: Family history in MHT casework

		Family History	
Case Accounts		**Yes**	**No**
Male	32	9	23
Female	12	11	1

This points up a difference with the twelve female cases where family history figures in all but one of the accounts. The exception describes a female client who is not directly the responsibility of the team. The client in question already has bed and

[1] Barrett states that clinical writing is 'the medium of case construction' and clinical talk that of 'moral evaluation' (1996:145). Byrd suggests that 'staff use moral evaluation to justify institutionally-oriented actions' (1981:123).
[2] Cf. the case of Agnes, an 'intersexed' person in Garfinkel (1992) - 'Passing and the managed achievement of sex status in an intersexed person, part 1' (pp.116-185).

breakfast accommodation which is outside of the team's catchment area. In this sense the client is atypical. All the remaining female cases invoke the client's family history to a great extent. Following Prior, this provides an 'explanatory score' for the work of the team (1993:2).

The following case extract demonstrates how the client's 'problem' is embedded in her socio-gender role as 'mother' (cf. Griffiths 1997:63).

Extract 7:1

11	CPNC:	and um, so I, she was quite difficult. I assessed her mental state um, when I saw her and I
12		fear she had a clinical depression, with no biological symptoms at all apart from a tendency
13		to [ ] noteworthy. She, basically, her history was that she was brought up in Baxter in
14		Yorkshire and came down to Western City with her husband, who she lived with, about
→ 15		fourteen years ago — um — that relationship broke up and she had three children aged
16		thirteen, fifteen and seventeen. After she's split up with her husband, um, she describes —
17		from being fairly stable to having, um, multiple sexual partners, um, and losing her job
18		and living in a Council place in Monkton [long pause]. She coped quite well for quite a
19		while but when they were sort of mid-adolescence, one was fourteen and the other six-
20		teen, she said she began to think she couldn't cope at all and she describes just thinking:
21		That was it — taking the keys to her house and giving them to the Council and saying:
22		I've left the child in the house, but I'm not having any more! And the other son was old
23		enough to leave home. She then went to Social Services and put the youngest one [ ]
24		saying that she was 'out of control' and she went to Paxton Street. I think that sort of
25		naturally um. Her life completely changed from being fairly secure in this house to living
26		in a homeless hostel and her history sort of, and stuff

CPNC's narrative draws upon a 'psycho-social' model of mental illness (cf. Griffiths 1997:69) in which the client's difficulties are accounted for in terms of her marriage break up (Ls.15-16). A change of social identity is accomplished through the ending of the client's marriage. No further information is given about the circumstances of the client's marriage other than it 'broke up' (Extract 7:1, L.15). This description of a broken relationship is indexically linked to the description of the client's children in terms of age (Ls.15-16). This functions to characterise the client as a vulnerable single mother with dependent children. Lines 13-14 describe her as a child from Yorkshire and later as a married woman who came down to Western City with her husband. She was married for 'fourteen years' (L.15) which implies 'respectability'. After she split

with her husband (L.16) her identity shifts to 'promiscuous woman' (L.17: 'multiple sexual partners') — 'unemployed woman' (L.17: 'losing her job') — and 'socially dependent woman' (L.18: 'living in a council place in Monkton'). This description of social decline is signified by the use of contrasting adverbs. The use of the passive case is more commonly associated with the role of women who are constructed as passive subjects:

Extract 7:2   (Part of Extract 7:1)

13 CPNC: .... She, basically, her history was that she was brought up in Baxter
14   in Yorkshire and came down to Western City with her husband, who she lived with, about

Her life whilst married is described as being 'fairly stable' (Extract 7:1, L.17). Even following the split with her husband she 'coped well for quite a while' (Ls.18-19). The client's ability to cope with life and with her role as mother constitutes 'wellness' in CPNC's account. It reflects on her mental state which might also be described as 'fairly stable'. 'Not coping' is defined in terms of the client's gradual inability to fulfil her role as mother occasioned by the adolescent phase of her children's lives:

Extract 7:3   (Part of Extract 7:1)

19 CPNC: ....but when they were sort of mid-adolescence, one was fourteen and the other sixteen,
20   she said she began to think she couldn't cope at all and she describes just thinking:

The client's moral identity as a mother is threatened by the CPN's description of her as not being able to cope with her children (L.20). The upshot of this challenge is a reconstituting of the client's identity as 'responsible' (cf. Goffman's 1972 concept of 'face-work'):[3]

Extract 7:4   (Part of Extract 7:1)

21 CPNC: That was it — taking the keys to her house and giving them to the Council and saying:
22   I've left the child in the house, but I'm not having any more! And the other son was old
23   enough to leave home. She then went to Social Services and put the youngest one [   ]
24   saying that she was 'out of control' and she went to Paxton Street.

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[3] Barrett states that moral definitions of patients are 'fragile' and 'subject to change' (1996:167). 'Moral rescue' at Ridgehaven is a staff accomplishment which transforms the value of the patient from negative to positive. (S)he can then be 're-assigned to a trajectory of progress and improvement' (1996:167).

In the previous extract, it is reported that the client gives her house keys to the council (L.21). She tells the council that she has left a child in the house (L.22). She takes the youngest child to Social Services (L.23). She is reported to have some insight into her inability to cope as a mother as she is said to have described herself as being 'out of control' to Social Services (L.24). CPNC describes the oldest son as being 'old enough to leave home' (Ls.22-23) which exempts the client from her caring role on his behalf. It is only after her children have been delivered into the hands of responsible social agencies that the client goes into a homeless persons' hostel (Paxton Street, L.24).

CPNC's description of the client's 'not coping' utilises a psycho-social discourse which interprets the client's 'problem' in terms of her socio-gender role of 'mother'. Historically and culturally speaking, this illustrates Turner's observation that women's social role occupies the *private* space of 'emotion and affection' (1990:94). Men on the other hand are allocated to social roles which occupy the space of *public* responsibility (cf. Segal 1988:xii). In Extract 7:1, L.12 CPNC attributed pathology in the form of 'clinical depression' to the loss of the client's socio-gender role of 'mother'. This interpretation also provides the team with grounds for 'decision making and action' (Holstein 1992:25).

A failure to display *concern* about the loss of the social role of motherhood is also pathologised in MHT accounts. The client description in the next extract constructs a case for female 'oddness' in the context of such loss:

Extract 7:5

```
 6  Y:    Services, um — I mean — [I] sort of felt she's had some extremely stressful life events
 7         last year. She lost her home, she lost her son, and she lost contact with her mother, and
 8         when I talked to her about all these things: It sounds to me like you've had a lot of really
 9         awful things happen — she's very oddly, not upset — very detached, and particularly
10         about her son — I mean, I said: Do you want me to contact the social worker about your
11         son — she just sort of said: Oh no — like that — really really unusual response,
12         although she did get quite tense when she was discussing that. Again, when I asked her
13         about her mother she just said: Well — I don't really like my mother anyway. She just
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The client is described as being 'not upset' and 'very detached' — particularly about her son (Extract 7:5, Ls. 9-10). This description is indexically linked[4] to oddness in terms of the client's gender and social role — 'she's very oddly, not upset'. The client is also reported to have turned down the opportunity to have news of her son via the social worker (Ls.10-11). Y's utterance on L.11 constitutes this response as being 'really really unusual' (L.11). It functions to construct an area of doubt about the client's psychological state. Y attributes this unusual maternal response to illness — the client being later described as 'quite tense' (L.12) when the subject of her son was raised. Like the female client in the previous extract — *this* client's 'problem' is also embedded in her socio-gender role of 'mother'. Interestingly, a clinical diagnosis of 'depression' is mooted in both. This supports Pilgrim and Roger's observation that depression is generally perceived as a 'female problem' (1993:43). It also supports Taylor and Field's observation that women are more likely than men to be diagnosed with a depressive illness (1994:72).

7.2 Male behaviour — its relationship to casework

By way of comparison, male case descriptions tend to focus more on behaviour.[5] They accentuate the active ie. 'doing things'. This opens up the possibility of choices, even if such choices are bad, and widening choice influences theoreticity. They frequently privilege antisocial behaviour as being of particular relevance to the case (cf. Holstein 1992:27). This is especially so when male behaviour is constituted as aggressive as the following case extracts demonstrate:

Extract 7:6

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46  CPNC:   ............... but  the  problem  fairly  recently  is  that  he's  been  drinking
47                — whiskey — um — although he denies it, but I've seen him all the time back and forth
48                on the train. There he is with his Telford's bag and his half bottle of whiskey, and — when
49                he doesn't have whiskey in him — he actually, you know, you can engage him. But with
50                whiskey, he's impossible. He gets very irritable, um, and quite verbally aggressive — um
51                — so basically, he's on sus, I mean, I saw him the other day, um — you know — to talk to
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[4]Pfohl's Lima State Hospital study also demonstrates 'the indexical nature' of interpretive processes (1978:130). Staff reflexively read into the patient's record - and the process 'seems to snowball' (1978:130). In Pfohl's work, indexicality is used to assist the picture of psychopathy. In the MHT study, it is used to assist the picture of psychological vulnerability.
[5] Prior (1993) states that 'the presence and nature of psychiatric disorder . . . was primarily encountered in terms of its behavioural manifestations' (1993:183). Here he is referring to the similarities between hospital based and community based care rather than to gendered 'images of disorder' (1993:183).

52	him about his behaviour and it's, you know, he really loves it at Scotsway. I convinced
53	him to lay off the liquor a bit but [ ] He said he would. He got quite irritable with me
54	as well. He said: Yes — he'd try and then, the night after, I saw him completely pissed out
55	at Topham Station, hardly able to walk. So really, he's on his final warning at Scotsway
56	now 'cos he's been really causing problems. I just really — want some advice on how to
57	carry on with this guy — what our actual involvement should be, um — because we have
58	tried quite hard to fill the scene on a couple of occasions and I see him weekly, and the
59	GP's involved, and the Scotsway staff give him, um, some support. And the positive thing

Unlike the female client in Extract 7:1 whose difficulties are accounted for in terms of her marriage break up — this client's 'problem' is described in terms of his drinking:

Extract 7:7   (Part of Extract 7:6)

46	CPNC: .... but the problem fairly recently is that he's been drinking
47	— whiskey — um — although he denies it, but I've seen him all the time back and forth

In Extract 7:8, it is reported that a worsening of the client's alcohol intake makes him difficult to manage:

Extract 7:8   (Part of Extract 7:6)

48	CPNC: .... There he is with his Telford's bag and his half bottle of whiskey, and — when
49	he doesn't have whiskey in him — he actually, you know, you can engage him. But with
50	whiskey, he's impossible. He gets very irritable, um, and quite verbally aggressive — um

CPNC's description of the client's behavioural lapse and social impropriety relates to gender in that it represents the 'active' or instrumental rather than the 'passive'. It is part of a wider description of antisocial behaviour which impinges upon the client's social status at Scotsway Hostel (Extract 7:6, Ls.50-56). Such a description not only provides a commentary on the client's behaviour whilst intoxicated. Following Holstein, it also provides 'a basis for evaluating and classifying' the client's suitability for continuing team support (1992:28). CPNC reports to the team that she saw the client 'completely pissed out[6] at Topham station, hardly able to walk' (Extract 7:6, Ls.54-55) and seeks advice as to how to proceed:

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[6] Barrett (1996) states that unprofessional terminology is an 'index of solidarity among staff members' who all face the same risk of injury whatever their 'rank or profession' (1996:150).

Extract 7:9   (Part of Extract 7:6)

55 CPNC: at Topham Station, hardly able to walk. So really, he's on his final warning at Scotsway
56   now 'cos he's been really causing problems. I just really — want some advice on how to
57   carry on with this guy — what our actual involvement should be, um — because we have
58   tried quite hard to fill the scene on a couple of occasions and I see him weekly, and the

The male client in the following extract is characterised as 'psychotic'. His behaviour is 'sequentially' described in the doctor's presentation of the case (cf. Holstein 1992:28). The doctor takes up the opening invitation which is provided by G, a CPN:

Extract 7:10

4 G: You know — I was thinking of the other guy that you mentioned you've been seeing

5 DR: Yeah — I was going to raise him because I'm going to see him with [doctor's name] with
6   a view of sectioning him later this afternoon. Just on the off-chance that he disappear
7   from Oakley House and just turns up. His name is [name of client] — an Hungarian guy
8   — um — very very psychotic — um — very thought disordered, full of a lot of delusions
9   about people injecting him with PC's, um. Thinks that the staff in Oakley House know
10   about it. Doesn't yet think that they're actually doing it to him, but he's convinced that
11   everybody else *knows* what's happening. And so — he gets very irritated with people. He
12   was chucked out of Bellmonts Hostel three times, ah, the last time because he was found to
13   have a hatchet, um

The client is described as someone who needs 'sectioning' (L.6). He is also described as being 'very very psychotic' (L.8). This provides the basis for the client's formal status under the terms of the Mental Health Act 1983. Later descriptions of the client as 'very thought disordered' (L.8) and 'full of a lot of delusions' (L.8) serve to justify the formal status which has been ascribed. His behaviour is accounted for in terms of 'irritation' with the Oakley House hostel staff (L.11). Such a description builds rhetorically on the client's previous characterisation as deluded (L.8). In Extract 7:11 below, DR's description provides an interpretive background which incorporates the client's earlier history:

Extract 7:11   (Part of Extract 7:10)

11 DR: everybody else *knows* what's happening. And so — he gets very irritated with people. He
12   was chucked out of Bellmonts Hostel three times, ah, the last time because he was found to
13   have a hatchet, um

Linking the consequences of the client's past behaviour with a description of the client's present behaviour sets up possibilities for descriptions of his future behaviour.[7] CPN2 takes the turn made available by DR's reference to a hatchet:

Extract 7:12

14 CPN2: He was actually threatening to use it

CPN2's utterance constructs a new description of the client as potentially dangerous to others. The turn made available through CPN2's new description in Extract 7:12 is taken up by DR. DR takes up CPN2's invitation:

Extract 7:13

15 DR: Right, so — again — if this gent turns up anywhere, he would be best seen with some-
16   body else, but I hope we're going to be able to get him in [to hospital]

In the extract above, DR's utterance on Ls.15-16 serves to confirm CPN2's description of the client as 'dangerous'. It also demonstrates and displays the team's 'planful arrangements' for managing dangerous clients (Garfinkel 1992:34). In MHT casework such descriptions are not entirely gender specific, but the notion of 'danger to others' is more often ascribed to male than to female clients (cf. Pilgrim and Rogers 1993:38). In addition, antisocial behaviour generally is more likely to be *labelled* in a way which refers to 'threat' in male cases (Pilgrim and Rogers 1993:38).[8]

The male client in the following extract is defined as conventional/theoretic or Category 'A' in Dingwall and Murray's terms (1983:135). He has been threatening to harm himself in a dramatic manner for the period of a week. Hostel care staff have approached the MHT for advice on how to deal with the client's behaviour:

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[7] Cf. Extract 7:36 and refer to discussion on p.173, footnote 12.
[8] In Pfohl's study, *potential* antisocial behaviour is also labelled as threatening. When accounting for the continuing use of medication with potentially violent patients one psychiatrist is reported to have stated: 'You know, you never leave the door that wide open. Not with these cases' (1978:98).

Extract 7:14

43 R: I was thinking about your — *particular* issue you were raising. I know you talked to me
44   about it in the week, and I spoke to Peter [the client] on Monday, about it and was/my
45   view about it at that stage was that it was really important for us to remain there and stick
46   very firmly to boundaries about what we'd negotiated with him in terms of your contract
47   of work — not to respond too much, well — the response to crisis should be the reinforce-
48   ment of, of those boundaries otherwise, you know, it's going to be a constant response to
49   crisis and I don't think that's very helpful. I was thinking about the issue of the staff. I

Reference to 'negotiated (L.46) and to the 'contract of work' (Ls.46-47) agreed

between the client and his caseworker constitute the client as theoretic (Extract 7:14).

In the next extract (Extract 7:15) his behaviour is compared with that of a female client

known to the team. The potential outcome for both clients should they act on their self

damaging tendencies is gender neutral. However, as the following extract

demonstrates, mitigating factors are utilised to account for the woman's behaviour

whereas none are given in the case of the man:

Extract 7:15

86 CPNC: It's almost to do with 'impulse control' isn't it? I mean — Sharon, she's got, you know
87   — she's a drug abuser, she's had bulimia, she's had all these 'impulse control' problems
88   and the — the — slashing, whatever, is just, you know — she gets the idea to do it and
89   she does it in front of your eyes, you know, and I think that's entirely different than
90   somebody going round saying: I'm going to cut my wrists [who] wouldn't do that[9]

91 R: Yeah. Yeah — exactly, that's — that's what I'm saying. I feel — you threaten to do it

92 Y: I mean, I think with this guy, every now and again he does it. I think his 'thing' is much
93   more about trying to control things by threatening — so yeah — because then he's been
94   actually threatening to do it since Monday hasn't he? I mean, I think you know, it's a
95   possibility that he *will* do something, but it's not — it's not the same

In Extract 7:15, Y ascribes the client to the generic male category — 'guy' (L.92). In

this male case 'deliberate self harm' is labelled as deviance. As discussed earlier in

this section, it is the antisocial aspect of the male client's behaviour which achieves

prominence throughout the account (cf. Holstein 1992:27). In the case of the female

client, similar behaviour is ascribed illness status ie. a disorder of 'impulse control'

(L.86), and the client is categorised as pre-theoretic. As with the notion of 'danger to

[9] Barrett states that nurses have 'extensive', but 'uncodified', practical knowledge about controlling violence that
takes the form of self-mutilation, suicide attempts or physical harm to others because they 'work at close quarters
to patients' bodies' (1996:54). This practical knowledge ensures that no patient or staff member is damaged during
violent situations.

others', the labelling of antisocial behaviour is not entirely gender specific. However, it would appear that the element of 'threat' in MHT descriptions of such behaviour is more pronounced in male than in female cases.

7.3 <u>Behaviour as an index of mental health</u>

Appropriateness of behaviour also appears to be gender related in mental health casework. Holstein observes that in mental health settings, behaviour is used as an index of mental health for 'a person of that gender' (1992:29-30; also cf. Byrd 1981:84). MHT data support this observation. The team's search for a 'match' between a client's gender and behaviour is demonstrated in the following case extract. The male client in question is caring for his step grandchildren — a girl aged ten and a boy aged nine. He has assumed the role of carer in the absence of his divorced daughter who is ill and his wife from whom he has separated. In the following extract, team talk focuses on the propriety of this arrangement and constitutes the children as being at risk from possible sexual abuse:

Extract 7:16

264	CPNC:	It's just when/I mean — it's that aspect of a single man wanting to have children living
265		with him. I mean, it might be perfectly alright

266	G:	When — when he, when he came round from stopping drinking and started to get better
267		he said, in actual fact — over twenty years, or twenty five years of his life was blotted out
268		with the drinking and he's trying to sort of — start living. And I suppose, in a way, it's a
269		bit of — sort of — making up lost time — or making up to society or to his family I
270		suppose. Um [pause] — well, he was saying things like, you know, he noticed that the bog
271		roll was completely used up [laughing] — so he thought: Oh my God — maybe she's
272		having a period. So he said: Oh you know the bog roll — you know sort of when girls get
273		to a certain age, you know. And this girl turns round and says: I know all that — and so —
274		shut him up. But he was ready prepared for all these things and he said his wife has a role
275		in that — some sort of/dealing with the woman's side of things he said. So he's sorted
276		things through really

In the extract above, CPNC describes the client in terms of his social status and gender — 'a single man' (L.264). He is reported to want to have children living with him

(Ls.264-265). In Extract 7:17, CPNC demonstrates 'doing doubt' on the appropriateness of this behaviour for a person of the male gender — falling short of an outright attack on the client's moral character by the use of the mitigator 'might':

Extract 7:17   **(Part of Extract 7:16)**

265 CPNC: with him. I mean, it might be perfectly alright

In the following extract, G (the client's caseworker) takes the turn made available by CPNC's utterance which constitutes an invitation to account for the client's socially untypical behaviour:

Extract 7:18   **(Part of Extract 7:16)**

266 G: When — when he, when he came round from stopping drinking and started to get better
267   he said, in actual fact — over twenty years, or twenty-five years of his life was blotted out
268   with the drinking and he's trying to sort of — start living. And I suppose, in a way, it's a
➔ 269   bit of — sort of — making up lost time — or making up to society or to his family I
270   suppose. Um [pause]

At first, this extract looks like a deviant case. 'Family' is invoked on L.269 — but in a different sense than in female cases. The sense invoked here appeals to the notion of males as economic providers.

G's new description of the client in Extract 7:18 represents the client's positive action to change his lifestyle and behaviour. He has stopped drinking (L.266). He is trying to 'start living' after twenty-five years of drinking (Ls.267-8). He is 'making up lost time' (L.269). He is making amends 'to society or to his family' (L.269). G's exploration of the social sphere (the client's behaviour) demonstrates a concern with the moral sphere — the client's motivation (cf. Strong 1979:55).

But G's description of the client as reformed drinker and reformed family member does not address the central challenge to the client's social and moral identity. The

inappropriateness of a person of male gender *wanting* to care for young children alone remains a 'trouble' in the talk. G attempts to manage this 'trouble' by giving an account of the client's actions when faced with a biologically specific dilemma whilst acting in the role of carer — that of female menstruation. The description which G displays to the team constitutes the client as a competent person of the male gender whose social identity is that of caring substitute parent. In Extract 7:16

- he shows an awareness of female biological changes — 'when girls get to a certain age' (Ls.272-3)
- he demonstrates an awareness of information-giving in keeping with the norms and expectations of concerned parenthood — 'this girl turns round and says: I know all that' (L.273)
- he has prepared effectively for his new role. This is verified by his having thought through a plan for managing any difficulties contingent upon this new role — 'his wife has a role in that — some sort of/dealing with the woman's side of things' (Ls.274-5)
- his social identity is that of competent male substitute parent — 'So he's sorted things through really' (Ls.275-6).

Like the fathers who occasionally presented at Scottish Paediatric Clinics in Strong's (1979) study, no 'assumptions' have been made about the child care skills of this particular client. That he has acquitted himself well in the untypical circumstances in which he finds himself is considered worthy of note in the case record (cf. Silverman 1987:256). But unlike the female client in Extract 7:1 whose role as mother represents female normality, *this* client's role as substitute father represents a male image of possible abnormality in the MHT context. This image of male abnormality is that of potential child abuser.

In the next extract, Y, the team's housing officer, takes the turn made available by G's utterance on L.276 in Extract 7:16

Extract 7:19

277 Y: I don't know *why* the wife can't have the children really

In the extract above, Y downgrades the extensive character work contributed to the account by G. Her utterance constitutes a challenge to the rationality of the team project. It serves to refocus attention on the inappropriateness of the male carer where the possibility of a female carer remains.

Elsewhere in the account the client's history of heavy drinking and sexual preoccupation is invoked:

Extract 7:20

247 Y: Is he still drinking?

248 G: No — no. He's stopped drinking completely now

249 CPNC: The other thing is — which I suppose sounds a bit/really horrible thing to say — but —
250   this thing about his genitalia — I mean — does he have any sort of — abnormal sexual
251   [pause] — I don't know — 'urges' or anything?

252 G: No

253 CPNC: I just wondered

254 G: It's a physical thing

255 CPNC: I just thought — with children around

In this sequence of interaction, CPNC returns to an earlier account of the client which describes him as presenting with an 'unrealistic — idea about his genitals' (Ls.25-26, not shown). CPNC reinvokes this description much later in the account after it is reported that two young children are living with the client. In Extract 7:21, the search for a 'match' between gender and behaviour which Holstein (1992) describes is demonstrated by CPNC:

Extract 7:21   **(Part of Extract 7:20)**

249 CPNC: The other thing is — which I suppose sounds a bit/really horrible thing to say — but —
250   this thing about his genitalia — I mean — does he have any sort of — abnormal sexual
251   [pause] — I don't know — 'urges' or anything?

In *this* case the search is for behaviour which suggests child abuse — or at least, the possibility of child abuse. This is a delicate issue and not one which is addressed directly. CPNC makes reference to it as 'bit/really horrible thing to say' — warning her audience in advance that what she has to say is indelicate in the extreme. In the next extract, what she has to say on Ls.250-251 is formulated in terms of a reiteration of what is known about the client's behaviour from the existing record:

Extract 7:22   **(Part of Extract 7:20)**

250 CPNC: this thing about his genitalia — I mean — does he have any sort of — abnormal sexual
251   [pause] — I don't know — 'urges' or anything?

In the previous extract, a pause marks the delicacy of this new description of the client which attempts to construct a link between the client's reported preoccupation with his genitals and the nature of his sexual behaviour. The descriptor 'abnormal' (L.250) precedes CPNC's description of the client's supposed behaviour. It constitutes an invitation to clarify what is known about the client thus far. G takes the next available turn and answers in the negative:

Extract 7:23   **(Part of Extract 7:20)**

252 G: No

In the next extract, CPNC does not single out the client's sexual behaviour for special scrutiny but couches her enquiries about it in terms of what 'any member might ask' given the case details reported so far:

Extract 7:24   (Part of Extract 7:20)

253 CPNC: I just wondered

254 G: It's a physical thing

255 CPNC: I just thought — with children around

Her general allusion to the client's sexual behaviour is functional to the case overall as it serves as a 'reminder' to the team that the possibility of child abuse cannot be totally excluded from its deliberations. As such, it implicitly keeps the issue of child protection at the forefront of decision-making if and when it occurs in mental health casework. In this particular case, child abuse is not verifiable, but the possibility of it remains a concern:

Extract 7:25

262 G: .... In a way, that's one aspect of Desmond that I'm not very clear
263   of/very sure of

Gender is also relevant in the context of psychiatric diagnosis and women's social behaviour. Although purely biological explanations of female mental illness have been mediated by socio-cultural explanations in recent years (cf. Prior 1993:142) — data from MHT case accounts indicate a continuing preoccupation with biology as an implicatory factor in women's experience of mental illness:

Extract 7:26

8 Y: .... She's/her name is Petra Glavinovic and um, she's a — a Jugoslavian woman
9   who's in her early forties. She was referred to the team by Craigie Street [hostel] because
10   she's at Craigie Street at the moment. She also referred herself to Nicky at the Oldfield
11   Centre because she'd lost her purse and she was actually asking to see a mental health
12   worker 'cos she was saying she was feeling quite depressed but also because she was quite
13   concerned about her menstrual cycle and her periods and she felt this might be linked to
14   that

In Extract 7:26, it is unclear whether or not the client's 'feeling quite depressed' (L.12) relates to the loss of her purse (L.11) or to concern over her menstrual cycle (L.13). This client characterisation links 'depression' to 'menstruation'. In this sense it represents how female bodies are discussed under the medical gaze — what Foucault has termed 'the hysterization of women' (1990:146). Mens' bodies are not discussed in the same way. Elsewhere in the case account the client's age is invoked:

Extract 7:27

155 Y: I suppose one of the things which just popped into my head was [maybe] something
156   which happened, like — of a sexual nature. That's the only thing that I, you know

157 PH: What age is she?

158 Y: She's in her early forties

159 PH: Is she menopausal? I mean — is that/I just wondered what age she was when she started
160   her periods, along with everything else of course

161   [LONG PAUSE]

162 CPNC: Sounds like Tanya Smallwood to me [another client]. Is she like Tanya? She's just
163   incredibly odd and eccentric; there's no — she's not psychiatrically unwell [   ] or is
164   she not like that?

165 T: No, she's not like that. She's not that demanding. She doesn't really seem to talk

166 CPNC: Right

In this instance, the team's search procedure fails to demonstrate a link between the client's present mental state and her menstrual history. Nevertheless it represents an aspect of MHT discourse which differs from its accounts of male clients of a similar age.

Later in the account the question of the client's libido is raised in the context of her having had a child taken into care:

Extract 7:28

182 R: I was just wondering if there's a — a connection, um [with] the issue of sex and perhaps
183   the loss of her child; significant trauma

'Significant trauma' in female MHT casework is commonly linked to loss of the social role of motherhood. The situation of a client already known to the team, Tanya Smallwood (Extract 7:27, L.162), is invoked for a second time. This takes the form of a moral tale:

Extract 7:29

209 CPNC: I suppose what made me think about Tanya Smallwood was that Tanya took to the streets
210   when her children were taken into care and [she] became — took on this sort of 'persona'
211   of a completely mad person dressed very peculiarly and, um, she wasn't seen for about six
212   months. I got some old notes from somewhere that basically said she wasn't meeting any
213   problems, and I asked her again about how she lived on the streets and she said: Oh, my
214   husband had an incestuous relationship with my daughter — and [she] just said that and
215   from then on, we talked about it and it was like — hugely traumatic, and she talked about
216   everything — well, you know, sort of the most intimate problems which she never
217   mentioned or talked about for fifteen years. So it might be something

Y takes the turn made available by CPNC's utterance on L.217 above:

Extract 7:30

218 Y: Yeah

Y's utterance in Extract 7:30 above, is a continuer. It 'works' to invite a new description of the *present* client made possible by the telling of the tale of Tanya Smallwood:

Extract 7:31

219 CPNC   And she'd got all these complaints [   ] — eccentric persona which she's taken on

The present client's status is now that of 'eccentric person' of the female gender — an attribute that is amenable to change or refutation.[10] This description of eccentricity

10 Barrett reports the case of Joyce, 'a woman in her late fifties' who had 'developed delusions that she was a Gypsy'. In the case discussion she was described as 'a weird character' who 'kept lots of rabbits' (1996:64-65).

builds on Y's opening description of the client as 'quite an odd looking woman' (Extract 7:32, Ls.15-16). The client is described as being 'odd looking' in terms of her gender rather than in terms of her personhood especially where this relates to her style of dress and facial appearance:

Extract 7:32

15 Y: . . . and she was really quite distressed and quite disturbed. She's — she's quite an odd
16   looking woman. She's quite a large woman and her appearance is slightly eccentric. She
17   wears incredibly flamboyant clothes — lots of long skirts that are actually down to the
18   ground, um — kind of /and the emphasis is like sort of/she wears kind of ethnic — which
19   might be to do with the fact that she's originally from Jugoslavia — but also, she's got bits
20   of lace tied round her head and scarves draped over her, and um, when Melissa saw her
21   she was wearing a very odd hat

22 M: Ties; mens' ties

23 Y: Mens' ties, hm. She also wears very bright make-up, um, and she [wears] incredibly pink
24   eye shadow which looks like it's lipstick actually; her cheeks are almost like a doll,

25   [BACKGROUND LAUGHTER]

26   and she wears loads of junk jewellery, but she also/last time I saw her she was wearing
27   home jewellery made from bits of wire like, um, you know, not like industrial wire, which
28   she'd made herself, and she was telling me she goes into skips and gets telephone cable —
29   strips of telephone cable and makes, uh, this jewellery, um. And she, um, she also — she
30   smokes cigars. I suppose that's not really that odd. Um, and a lot of the times I've seen her,
31   um — around the hostel, but also, I saw her in the street [one time] when I was going to
32   see her — [I] bumped into her — she carries a teddy bear as well.

In the extract above, Y's account draws on notions of the social face as 'public face' (cf. Synnott 1990:61). The client is described as 'quite distressed and quite disturbed (L.15). Y 'works up' this description of 'an odd looking woman' (Ls.15-16) introducing additional information about the client's appearance. This new description represents the client's social unmasking in conditions of extreme emotion. Y's description promotes an image of the client which does not conform to social norms of female attractiveness or dress. She is 'large' (L.16) and her appearance is 'slightly eccentric' (L.16). She is reported to wear not just 'flamboyant clothes' (L.17) but 'incredibly flamboyant clothes' (L.17). These include skirts so long they are 'down to the ground' (Ls.17-18) and 'bits of lace tied round her head' (Ls19-20). Scarves are

not tied but 'draped' over her (L.20) suggesting a certain lack of concern. Her 'very odd hat' (L.21) is made up from mens' ties. (cf. Byrd 1981:48 where odd dress is seldom used as an indicator of mental illness. When it is, it is applied to women rather than to men). The inappropriateness of the client's facial make up is also described with her general appearance resembling that of a doll (Ls.23-24). The inappropriateness of the client's actions support Y's description of eccentricity. She is reported to visit waste skips to retrieve strips of telephone cable from which to make home jewellery (Ls.26-29). In addition, her behaviour does not conform to her adult status as she 'carries a teddy bear' (L.32).

How Y and other team members collaborate in producing this eccentric client owes much to popular cultural stereotypes of feminine beauty. The client is described as physically and visually different from this implied stereotypic ideal. The discrepancy created in the client's social identity by being described as 'odd looking' (Ls. 15-16) leaves an area of doubt as to her emotional 'make-up' (cf. Goffman 1979:12-13). To be 'odd looking' is a moral indictment.[11]

The notion of a public mask 'slipping' is applicable to men too of course as the following extract demonstrates:

Extract 7:33

4 G: Well — a very quick mention of somebody I'd like to share information with. It's a chap
5 called Tony who's, uh, twenty — nine year old man still living in Hollyview. I picked him
6 up there in July of this year. Ah — main reason for referral was that he was very very pre-
7 occupied with religious tapes and that he thought there was some sort of 'gangland' people
8 after him. And — when I saw him he was [pause] — a very pleasant um, very nice
→ 9 pleasant man — but on closer interview, he was holding a lot of very elaborate delusions
10 and ideas about people knowing what, uh — plotting against him.

Here the client is described as a 'very nice pleasant man' (Ls.8-9) — until he is interviewed more closely (L.9). This 'closer interview' is reported to reveal the 'reality' of the situation which is that the client is deluded (L.9). G's description

[11] See 'Doing being ordinary', in Harvey Sacks, 1992, Lectures on Conversation, Vol. II. pp.215-221, Oxford: Blackwell. Sacks (1992) shows how everyday life is a practical accomplishment so that we need to work at 'being ordinary'. Also see Byrd (1981). When staff interpret behaviour as 'eccentric' rather than as pathological, they report more positively on the patient's functional level. In outpatient practice, this defines the case as 'lying outside the boundaries of professional interest' (1981:55). In MHT practice, it assists the case for vulnerability.

demonstrates the documentary method of interpretation — like all the data indicate. This is a particularly nice example because of the use of 'closer' (L.9).

In this sense, MHT caseworkers are 'people producers' (Holstein 1992:24). The people they produce are those who are constituted as being unable to sustain a reliable public face. Such people are descriptively constructed as eligible for team engagement. The team's primary work is to identify mental ill health in the community. Gender is relevant to the case described in Extract 7:26 as the client is constituted as a vulnerable, homeless female in terms of her mental and gynaecological health. Engaging her is the immediate practical issue for the team as this will secure an assessment. In Extract 7:34, the grounds for this engagement are eventually formulated by the team doctor:

Extract 7:34

389 DR: She needs to have her street status established as well if she's been sleeping on the
390   streets. Her GP could do a physical screening

By way of comparison, the gender of the client in Extract 7:33 does not immediately appear relevant to the case. However, it *becomes* relevant to the case at a later stage when G offers additional information about the client's mental state:

Extract 7:35

20 G: and I thought, it's the first time I've seen him sort of 'reacting' to perhaps a delusional
21   thing. In actual fact, what had been happening was that he had recently been seen by the
22   Welfare Officer who felt that he would have to leave Hollyview. And the main reason was
23   that there had been a spate of thieving from the men's lockers, and Tony had been suspected
24   of stealing from the residents, which quite concerned him.

Describing the client as deluded implies that the 'pleasant man' of Extract 7:33, L.9 has become the potentially *un*pleasant man who is deluded (Extract 7:35, Ls.20-21). This tacit description of an unpleasant deluded man is 'typically associated' with male casework (cf. Holstein 1992:32). The description has the additional connotation that the behaviour of such a man is potentially harmful. In this sense, the case has

similarities with the client description already discussed in Extract 7:10. The immediate practical issue for the team now becomes maintaining the client's hostel place so that his behaviour and actions can be monitored. Being described as deluded in Extract 7:35 provides an alternative interpretive frame to explain the antisocial activities of the client which might otherwise constitute him as a thief, Ls.23-24 (cf. Holstein 1992:32). 'Thieving' implies an active choice and would define the client as conventional/theoretic (Dingwall and Murray 1983:135).

As discussed in 7.2, male client descriptions in MHT casework tend to accentuate the threatening aspects of client behaviour rather than the client's physical appearance. This is demonstrated in the extracts which follow. In Extract 7:36, the client's good behaviour whilst on medication is seen as 'proof' of underlying illness (cf. Pfohl 1978:102). On L.114 (not shown), CPNC reports that the client has been 'very well'. Ensuing team debate focuses on the client's need for continuing medication:

Extract 7:36

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128 CPNC:   to think that — he realises that there's much less hassle. 'Cos he was quite — when he
129          was — uh — unwell — he was quite dang[erous] — he actually took a four storey flat —
130          and took the children of the people he was saying with — and one, I think, was a small
131          baby — and tried to drop her over the balcony because he believed that the children were
132          possessed — he's [laughing] — dangerous when he's not on — medication and so he's
133          somebody I, you know, that I'd feel quite worried about if he's not on medication
```

CPNC's description produces an image of client dangerousness in the context of untreated mental illness ('when he was - uh - unwell', Extract 7:36, Ls.128-129).[12] The description is of a deluded male person who might be capable of harming a baby. The notion of the 'mandatory preciousness' of children compounds the dangerousness of the client's behaviour (Dingwall and Murray 1983:143).

The description of male client dangerousness in the next extract is accomplished in terms of criminal activity ('forensic history', L.14).

[12] In this MHT study the *threat* of dangerousness is used as an indicator of future violence should the client be left untreated ie. without medication. This is similar to Pfohl's (1978) study where psychiatric decisions are relied upon to predict future dangerousness (1978:18). In Pfohl's research, such decisions determine the need for 'future hospitalization'. A patient history of actual violence is used as the sole predictor of future violence (1978:19). In the MHT study, a history of dangerousness is used to justify the need for continuing medication. Also cf. Extract 7:11.

Extract 7:37

14 CPN2: Metropolis, um; he's got a long forensic history, but I'll wait for notes — but apparently,
15 in the Metropolis Day Centre, he's a very dodgy character to have around women.

The description of the client in the case record is indexically linked to his present, observable behaviour which is constituted as 'dodgy' whilst 'around women' (L.15). The nature of the behaviour is not precisely defined. That it is particularly risky to women rather than men implies sexual threat even though this is not openly stated.

In cases where the risk of sexual threat is acute, physical descriptors of the client upgrade the overall description of male threat as the following extract demonstrates:[13]

Extract 7:38

71 CPN2: Well, yeah — ah — their main concern originally was that he was following women
72 about at night — and he's a big guy — very close to them, and staring at them. And they
73 were quite concerned about him, especially over weekends

In the extract above, the client's physical appearance is described as 'big' (L.72). It refers to a person of male gender ('guy', L.72) who is known to follow women around at night (Ls.71-72). This description has different connotations to that of the female client in Extract 7:32 who is described as 'a large woman' (L.16). In the female case, the client's 'largeness' amplifies the eccentricity of her bodily appearance. In the male case, by contrast, the client description does more than provide a commentary on his physical appearance. It also conveys the notion of threat.

The exceptions to descriptions of masculine threat/antisocial behaviour are those relating to male clients of advanced years or to male clients whose diagnosis precludes the threat of harm to others. In the extract which follows, an elderly male client is being moved from a hostel to a nursing home against his will:

[13] This contrasts with Pfohl's (1978) observations at Lima Hospital where sexual assault without accompanying physical injury was not categorized as dangerous (1978:106). This possibly reflects the setting in which Pfohl conducted his research ie. an institution for the criminally insane. The likelihood of patients being discharged from such an institution would be low.

Extract 7:39

```
10  R:   One of them was sort of saying — poor old bloke — eighty-four years old — George
11       McKinnery — been at Prescot House for donkey's years — and it was a mammoth task/he
12       completely denied that Prescot was closing — wouldn't consider any other housing until
13       the day it actually shut. And then he gave himself up at Renton Magistrates' Court think-
14       ing that he would rather be back in prison. He eventually got to Jubilee House, settled in
15       nicely [          ] — he's been there eighteen months, and now they, you know — he's just
16       settled down and now they want to move him again. And he's worried because they're
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The male client in Extract 7:39 above is constructed as a victim of society rather than as a threat even though his 'history' indicates that he has a prison record ('he would rather be back in prison', L.14). He is described in terms of his lack of economic status — 'poor' (L.10). He is also described in terms of his age ('old bloke — eighty-four years old', L.10). He is ascribed to the generic, inoffensive male category — 'bloke' (L.10).

The particular description of the client which is given highest prominence overall is his aged status. He is not just described as 'old'; he is an octogenerian. That this particular old man is about to be moved to a nursing home against his will (Ls.17-19, not shown) problematizes his situation in terms of his personal autonomy. The description of his actions on Ls.13-14 labels his victimhood and also sentimentalizes it to a certain extent. Such a description subscribes to what Fennell et al (1991:6-7) refer to as a model of pathology — where old people's lives are seen as a 'natural' and unavoidable problem almost without question (cf. Simms 1989:192).[14] Pfohl (1978) identifies a similar phenomenon in his Lima Hospital research where behavioural 'aberrations' in elderly clients are attributed to 'incursions of senescence' rather than to mental illness (1978:99). However, Byrd's study demonstrates the opposite. Because of the outpatient clinic's need to find elderly clients for one of its staff training programmes, 'no person over sixty-five years . . . received the diagnosis of a non psychiatric problem' (1981:87).

[14] One can only speculate about the lives of elderly women as no data in this area is available from MHT casework. See Barrett's (1996) Ridgehaven study for the case of a sixty-four year old woman whose eccentric and bizarre behaviour was greeted with 'hilarity and amazement' by staff members (1996:93). Accounts of the patient's sexual interest were reported as being comically absurd (1996:93).

MHT casework points up both a similarity and a difference in team descriptions of male clients at different ends of the age spectrum. The similarity is that client descriptions of vulnerability in terms of housing remain 'situationally relevant' to the case (Holstein 1992; also refer to 3.2 for previous discussion). The *difference* with older male clients is that their behaviour is no longer labelled as threatening. They are redefined in welfarist terms primarily as social problems rather than as a social threat.

Other male cases which differ from the more common 'antisocial' type are those of male clients who are described as too ill to pose a threat. The following extracts demonstrate how the MHT 'does' such descriptions:

Extract 7:40

➔ 114 R: He's very very depressed

115 CPNC: It's — it's awful — yeah. And he just sits there now and he says to me — the last time I
116   saw him just for half an hour and he just kept saying: Worse and worse, worse and worse,
117   worse and worse

➔ 118 Y: Oh — poor man

In Extract 7:40, R describes the client in illness terms — 'depressed' (L.114). The description of the client as ill is reinforced by the use of an additional 'very' (L.114). CPNC takes up the invitation made available by R's utterance and describes the client's behaviour. The purposelessness which she describes ('he just sits there', L.115) serves to endorse R's description of the client as 'depressed'. The upshot of CPNC's description of the client's behaviour is the registering of surprise by Y: 'Oh' (L.118). This signifies a change in the team's labelling of the client. He is described as 'depressed' on L.114, which is a broad diagnostic label. By L.118 he has been reconstituted as a person of male gender for whom we should feel sorry ie. a victim ('poor man', L.118).[15] Y's new description of the client also identifies him as non-threatening.

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[15] Pfohl (1978:100) states that staff make 'clear-cut judgements about the absence of mental illness' in the context of a patient's physical deterioration.

The male client in the next extract has been admitted to the specialist burns unit of a military hospital. This extract relates to the argument in that it describes a male client who is constructed as non-threatening in terms of gender. It also demonstrates how male descriptions are done in relation to particular features of visual appearance. The male client in Extract 7:41 is reported to have 'cuts on his face and stuff' (L.168). M's description of the client as falling over or as one who has been the recipient of antisocial behaviour by others — establishes the client as a victim. It also identifies him as non-threatening. The description of facial appearance in *this* case is used to compound the overall construction of the client as victim. This points up a difference with the description of the female client in Extract 7:32, Ls.23-24 for example, whose facial appearance is compared to standards of female attractiveness. In MHT casework the documentary method of interpretation is done in a gendered way. There is a qualitative difference in what counts as 'appearance' in descriptions of male and female clients.

Extract 7:41

166 M: And where he — he was street homeless when I first started working with him so I
167   arranged for him to be seen there because it's not very [   ] to be on the streets where he
→ 168   would come in with cuts on his face and stuff

169 G: Mm

170 M: He was either falling or people were giving him nonsense

In the extract above, M, the team's social worker, describes the client as 'homeless' (L.166). The description of the client in social welfarist terms is reinforced by the additional descriptor 'street' which is linked to 'homeless' (L.166). This suggests that the client has absolutely no access to accommodation of any sort and that he is literally living on the streets. The client's behaviour is *not* described in this instance. However, M offers a description of the client's physical appearance instead 'with cuts on his face and stuff' (L.168). G takes the turn made available by M's utterance and provides a continuer 'Mm' (L.169). M accepts the invitation made possible by G's utterance:

177

Extract 7:42   (Part of Extract 7:41)

170 M: He was either falling or people were giving him nonsense

Having examined how members use behaviour as an index of mental health, I will now examine how sexual vulnerability is constructed in a gendered way. I will explain how this is interactively accomplished by returning to the data.

7.4 <u>The gendered construction of sexual vulnerability</u>

Sandy, the female client in Extract 7:1 is constructed as sexually vulnerable (L.17) following the collapse of her marriage. Earlier, in Chapter Six, Extract 6:16, another female client (Kim) is constructed as being the victim of 'extremely violent relationships with men' and has been 'badly injured by them' (Ls.37-38). Neither woman has much in common, but as Loseke (1989) points out in her work on a shelter for battered women, varied characteristics and experiences become homogenous 'social types' through worker activity. She refers to this as 'social problems work' (1989:185).

In the case of Sandy, the first client mentioned, the description of sexual victimisation is perpetuated and enhanced when new knowledge is raised about her having sexual relations with a male psychotherapist who is married. Its delicacy is marked by pre and post-episodes of coughing (Ls. 39 and 40):

Extract 7:43

38 CPNC: [   ] [She] started having sexual intercourse, and had been having sex with her therapist
39   which [cough] although he said he was married, she'd offered to — I think she's very
40   damaged by [   ] and I think it's, from our point of view, just not on [cough]

The upshot of the team's interaction is that the therapist is constructed as a charlatan. Members laugh and make play on the word 'therapist' to reconstitute it as 'the rapist' (L.65, not shown). Laughter here functions as a moral indictment against the therapist casting doubt on his competence as a professional and on his character as a man. It

also functions to cast doubt on his trustworthiness as a husband which challenges his social status. Interestingly, this is the opposite of how laughter generally functions in MHT casework where it *maintains* the morality of clients' actions (cf. Dingwall and Murray 1983).

This characterisation of the male therapist distances him as a contender for client care and adds to the construction of the female client as victim in terms of her sexual gender. The outcome of the team's interaction is that a female caseworker is assigned to the client to help her end the relationship. This is not an arbitrary arrangement. The caseworker selected is one whose informal social identity within the team is that of specialist in women's issues:[16]

Extract 7:44

85 CPNC: I feel quite confident in working with her to help her stop it continuing

In MHT casework it remains a matter of conjecture as to whether a male client might be afforded advocacy in quite the same terms as the female client as no data is available from this setting. However, fieldwork notes reveal one example of a male client who is offered a 'men's group' as a means of support in coping with physical rather than sexual, abuse by his father although he is not offered specialist intervention. This is possibly because the abuse is in the past. That Sandy's 'problem' is constituted as a lack of assertiveness suggests that female clients *are* treated differently from male where sexual transgression is demonstrated. Women are more commonly associated with a passive social role than are men, an ascription which has already been discussed elsewhere (see page 155).

By way of comparison, Hoffman (1992) makes an interesting observation on gender and categorization devices in American mental health practice. Clients like Sandy are categorized as having 'Self-defeating Personality Disorder'. In other words, the

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[16] Fieldwork notes record that team members subsequently preface similar cases with: 'Here's one for you Linda'. Byrd (1981) makes a similar observation in the psychiatric outpatient setting where staff request 'particular kinds of clients'. Such clients equate with the needs of particular treatment programmes (1981:33). However, the orientation of Byrd's staff is specifically psychotherapeutic whereas MHT staff have a much broader social and interpersonal focus.

reported inability to leave an abusive relationship is described as an illness (1992:9). In keeping with past discussion (p.154), I suggest that the pathologising of Sandy's lack of assertiveness in this study represents an example of how caring professionalism is constituted to manage a local contingency. Like the male client, Frank, who wants to sack his caseworker (Extract 8:69) — Sandy's biography too remains that of psychiatric patient (cf. Goffman 1979:86). This is organisationally functional to the team's work. In addition, computerised case disposal records only show that the team's final decisions accord with their primary objective. This is to serve single homeless people with mental health problems. This supports Loseke's findings who states that in shelter work:

'In theory and in practice, it was women of the "battered woman" type
who should be served and who could be served' (1989:191).

However, putting institutional needs to one side, McNamee and Gergen (1992:3) point out that describing such a client in mental illness terms places blame on the client rather than the social circumstances in which she finds herself. This might be construed as 'oppressive' from some feminist perspectives. Any practice is always two-sided.

Sexual vulnerability in female mental health casework is used to account for social needs in terms of housing. Kim, the client in Extract 6:16 for example is in danger of being evicted from her hostel because of her use of illicit drugs. To meet this contingency, members work up a description of the client's physical health which constructs the need for her to attend hospital appointments for the treatment of uterine cancer. This infers the additional need to maintain the hostel place so that appointments can be kept:

Extract 7:45   (Part of Extract 6:45)

157 CPNC: They won't mind [if] they think she's going for something for Cancer [pause], you know
158   — bring up the gynaecologist

This and similar findings supports Holstein's research on the way that caseworkers use gender in their everyday discourse. Holstein refers to descriptions of clients as 'reality projects' (1992:25). Gender is invoked in deliberations on proposed living arrangements. He describes the outcome of a case where a female client was living in a cardboard box by the railway tracks. This situation was perceived as inappropriate for a woman by the legal authorities — the inference being, because of the risk of physical/sexual harm. In a similar way, female MHT clients are described as being more at risk through rough sleeping than are male.

7.5 Conclusions

In summary, this case study of MHT casework focuses on everyday practice. It differs significantly from the analytic perspective of structural sociology and from feminist approaches which point to the gendered nature of meaning (Silverman 1993:25). It demonstrates how gender is used by members to make sense — inductively — in casework. This contrasts with the positivist approach which Cuff and Payne suggests has a tendency to ignore:

'the indexical properties of interaction' (1989:212).

As I discuss later in Chapter Nine (see 9.3; also see pp.267-268), there is a need for a greater focus on how gender is locally accomplished (see Frith and Kitzinger 1998). In that chapter, I underline the importance of client descriptions as a resource through which the MHT legitimates its interventions.

So far, this study has analysed how clients are constructed by the MHT. I now want to change focus and examine how team members themselves are constructed. The chapter which follows is entitled 'Constructing the Mental Health Team.'

Chapter Eight: Constructing the Mental Health Team

Casework talk demonstrates and displays MHT competence. It is both a ritual enactment and celebration of, the practical reasoning of the team. Through their talk, MHT members constitute themselves as experts in mental health care. This necessitates the distancing of other professionals working in the same field of care. *How* the team accomplishes this is a methodological issue. As professionals, team members demonstrate claims of access to the 'reality' of a situation. Members speak as if they could not have done otherwise, given the situation, but other agencies could. In other words, members work at depicting their situation as 'non-conventional' whilst depicting other agencies' situations as 'conventional'.

Analysing casework talk gives some insights into the issue of conventionality as applied by the team to itself and to other agencies. Like files, accounts shed light on the practical decision-making of the team in the context of:

'the constraints and contingencies of their work' (Silverman 1993:65).

As in Chapters Five and Six which describe the construction of the client, constructing the team is also accomplished through the use of interacting frames.

This chapter will focus on the construction of the team's identity as experts in the field of mental health care. This is an organised social accomplishment which involves the distancing of competing claims to expert knowledge. In this sense the account can be viewed as a narrative in which members display their specialist knowledge and opinion. Like Atkinson's work in the haematology setting, the team narrative:

> *'distributes credibility between the narrator and other dramatis personae'* (1995:95).

Frame changes are integral to this process. They are utilised on a continuous basis to manage troubles in the talk and to construct the MHT's biography of professional expertise. The use of the clinical or psychological frame will now be examined in relation to constructing the team as mental health experts.

8.1 Participation frameworks

Frames facilitate the organisation of meaning, but they also organise 'involvement'. Reconstitutings in casework talk thus have very real consequences for the team. Goffman suggests that the essence of the issue is the relationship of the speaker to himself 'as someone about whom he is speaking' (1974:512). What emerges from this relationship emerges against a background of cultural standards. This is instrumental in the construction of social roles.

Changes of frame occur, episodically, throughout the MHT case accounts. Situational meanings emerge with each change of frame. Following team deliberation, consensus is reached and an action plan agreed. It is a collaborative effort which provides for 'the rationality of' the team's project. (Silverman and Jones 1976:161). Whether or not an account is recognizably 'good' is based on a retrospective process which examines the 'facts' of the case (cf. Garfinkel 1992:107).

In order to construct the 'seriousness' of the account, the facts of the case have to be 'displayed'. The intelligibility of the account has to be meaningful to the community it addresses (Silverman and Jones 1976; Atkinson 1995). The team's adherence to overt and covert 'rules' in the account testifies to its community and philosophy of care, but not to any other. Having established the case context, the account is 'tested' to demonstrate that it is in accord with a community rule and embedded in communally sanctioned methods of procedure. For instance, the 'serious' case account must testify to the clinical 'facts' and their consequences as any member of

the MHT might see them (Silverman and Jones 1976:155). An example of 'expert talk' is demonstrated in the following case extract:

Extract 8:1

27 CPNC: Well, he hasn't been that dramatic at the time that I've been meeting with him. He just
28   presented really, you know, he was referred to me because he was quite low [in] mood and
29   that sort of thing, so DR and I saw him and — the feeling was that he was clinically
30   depressed, but he had a lot of reason to be really, um, and DR started him on anti-
31   depressants, um. Before the antidepressants reached therapeutic levels and stuff — he sort
32   of had crisis one day — said he wanted to chuck himself under a bus and [   ]. He would
33   have been sectionable when I saw him but there was nobody around to come and see him
34   immediately. So we gave him some Valium and he settled a bit and the GP actually came
35   that afternoon and the Valium had settled him and things — um — so what we've been
36   trying to do really is to give him a full medical assessment, um, and I'd try and do some
37   support work — some counselling — about his mother and stuff

The client's difficult behaviour, which is an area of concern for the hostel staff, is downgraded by CPNC (L.27). A diagnosis of 'depression' is attributed to the client (Ls.28-31) rather than that of 'alcohol abuse' which is the description given by the hostel staff (L.25, not shown). CPNC's description now has to be 'proved' and she attempts to do this by constructing a narrative around the client's mental state. This ancillary account promotes the idea that the client might well have committed suicide had it not been for the timely intervention of the CPN and DR, the team psychiatrist (Ls.31-35). The account has authority. *Any* member of the MHT community would follow a similar course of action given the same circumstances.[1] The 'fact' that the intervention was a success is further endorsement of the 'seriousness' of the account:

Extract 8:2   (Part of Extract 8:1)

34 CPNC: .... So we gave him some Valium and he settled a bit and the GP actually came

In the extract above, the team's intervention is marked by the administering of medication which is reported to have induced a beneficial response from the client (L.34). The positive outcome of the intervention is witnessed by the client's GP:

[1] Pfohl's (1978) research is also concerned with 'typification' work through which members indexically single out 'a certain aspect of an individual's multifacited presence in a particular context' (1978:49). By such means, individuals are categorised as mentally ill. Like the client in Extract 8:1, the 'seeing' of the attributes of mental illness is 'taken to represent a seeing of who the individual really is' (1978:49). Diagnosticians then present 'reasonable accounts' of the 'adequacy of particular labels' (1978:50).

184

Extract 8:3 (Part of Extract 8:1)

34 CPNC: .... So we gave him some Valium and he settled a bit and the GP actually came
35　　　　that afternoon and the Valium had settled him and things — um — so what we've been

There is also the inference that the team's intervention has been documented. Ls.36-37 in the following extract describe how members of the team have endeavoured to give the client 'a full medical assessment':

Extract 8:4 (Part of Extract 8:1)

35 CPNC: that afternoon and the Valium had settled him and things — um — so what we've been
36　　　　trying to do really is to give him a full medical assessment, um, and I'd try and do some
37　　　　support work — some counselling — about his mother and stuff[2]

The team's success and professional competence becomes part of the case record. The account of the successful intervention upholds the team's professional authority and validates its skills. The type of person formulated by the narrative is the mental health 'expert' — one who possesses a body of expertise exemplified by the use of a specialised case worker language shared by other members of the MHT community and applied appropriately (L.34, 'So'):

Extract 8:5 (Part of Extract 8:1)

32 CPNC: had crisis one day — said he wanted to chuck himself under a bus and [　　]. He would
33　　　　have been sectionable when I saw him but there was nobody around to come and see him
34　　　　immediately. So we gave him some Valium and he settled a bit and the GP actually came

Extract 8:5 demonstrates and displays team competence in crisis management. The client is reported to have 'had crisis one day' and become suicidal (L.32). The likely outcome of this reported crisis is said to be the application of a section of the Mental Health Act ('been sectionable', L.33). The contrast between 'then' and 'now' drawn by the narrator (Ls.33-34) contrasts the shortcomings of the hostel staff and hostel GP with the expertise of team members CPNC and DR. It is implied that 'they' were not

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[2] MHT transcripts are of members' accounts alone. This differs from Pfohl's work in which transcripts of interviews with designated patient leaders are also utilised. Through such means, Pfohl hoped to gain additional insight into the way that patients viewed the review process in order to shed more light on the psychiatric assessment process overall (1978:64). Triangulation is not used in the MHT study.

around to see the client immediately (Ls.33-34). The use of the pronoun 'we' points up the contrast between the two care teams — identifying the MHT as the experts ('So we gave him some Valium and he settled a bit', L.34). The use of contrasting pronouns is a common phenomenon in MHT casework (cf. Atkinson 1995:103). This will be explored in greater detail, later, in this chapter (refer to 8.3).

Occurring alongside the team's characterisation as expert is the distancing of competing agencies for client care. How this distancing is done through interacting frames, is the subject of the next part of the analysis.

8.2 Distancing other agencies — the MHT as 'experts'

The distancing of competing agencies is a continuous process. It subtly infiltrates the casework talk and it demonstrates an understanding of the fears and constraints of the work of other professionals. Sometimes it takes the form of dismissiveness towards the competence of other professionals. On other occasions it has a more 'shaded' character — pointing up a deficit in care which the MHT might fill. The following extract demonstrates how the team eliminates other professionals as possible advocates:

Extract 8:6

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171   TL:    'Cos when M told me that the psychologist was involved I said: Whoopee, give us —
172          give us an assessment — but she was only asked to see him because he was peeing in the
173          bins or peeing on the floor [laughing] — probably why he needed a behav — behavioural
174          programme you know
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In this extract, it is the referral to the psychologist which is being characterised as ridiculous ('but she was only asked to see him', L.172). CPNC takes the next turn and her utterance on L.175 is heard as an indictment of other agencies involved in the client's care:

Extract 8:7

175 CPNC: It's a shame — a disgrace

In Extract 8:8 below, R takes the next available turn and compounds the description of other-agency incompetence:

Extract 8:8

176 R: They didn't do a cog — a cognitive assessment?

— the inference being, 'as the team would have done'. The upshot of CPNC's utterance on L.175 is R's utterance on L.176. This is produced within the clinical or psychological frame. On this occasion, the psychological frame is utilised for a particular contingency — that of constituting the team as mental health experts. It is both a response to the 'trouble' of competing agencies and a remedy to such trouble. This use of the psychological frame will be examined in more detail in Part III.

The team's active collaboration which is demonstrated in Extracts 8:6 to 8:8, eliminates the psychologist as knowledgeable expert and as possible advocate. She has failed to produce the necessary assessment, placing the client on an inappropriate behavioural programme instead. TL's laughter in Extract 8:6, L.173 marks the rule breaking (rather than the rule breaker) which preserves the client's pre-theoretic status (Dingwall and Murray 1983:135). It also functions to downgrade the psychologist's skills so distancing her as a contender in the provision of advocacy. However, positioning the team to intervene clinically is not accomplished till L.192 of the account as the following extract demonstrates:

Extract 8:9

192 DR: I think the first step is to go round and um — up the interview a bit[3]

[3] The team doctor here is demonstrating his medical competence. In his Lima Hospital study, Pfohl (1978) states that there are many different identities available to diagnosers. He lists 'competent expert', 'dedicated reformist' and 'good guy who'll help out on the weekend' as possible identities (1978:51). The importance of such identities 'lies in their potential for becoming self-typified rationales for the interpretive work of psychiatric decision-making' (1978:51). Also see Extract 8:39, Ls.224-225.

187

Before this team intervention can occur, a doctor who might be working at the client's hospital, also has to be distanced. This process of distancing is marked by a change of frame to the practical. Extract 8:10 (below) demonstrates further team collaboration which distances the doctor who might be involved in the client's care. Working backwards and then forwards through transcript material gives insights into how this doctor is 'talked out' of the account. L.184 represents the first utterance of side two of the tape. It is the upshot of an unrecorded sequence of verbal interaction between two team members in which the likelihood of certain doctors being involved in the case is discussed (fieldwork notes, Tape 12, Case 3, not shown):

Extract 8:10

184	G:	Senior Reg. or something wasn't he?
185	DR:	Oh — Vythilingum
186	Y:	Perhaps it's worth writing to him?
187	G:	I wonder whether he works for the Queen Margaret Military Hospital?
188	CPNC:	He worked for the Army
189	TL:	He left to go to the Falklands didn't he?
190	DR:	Yes
191	R:	So the first step
192	DR:	I think the first step is to go round and um — up the interview a bit

DR's utterance (L.192) is the upshot of R's utterance on L.191 which signals team opportunity to intervene in the case. R's invitation is the upshot of DR's previous utterance on L.190 which is heard as confirmation of TL's utterance regarding the posting of the Queen Margaret doctor. The giving of this information is made possible by CPNC's previous utterance on L.188:

Extract 8:11   **(Part of Extract 8:10)**

188   CPNC: He worked for the Army

CPNC hears G's utterance on L.187 as a request for clarification:

Extract 8:12   **(Part of Extract 8:10)**

187   G: I wonder whether he works for the Queen Margaret Military Hospital?

G's utterance (L.187) is the upshot of the housing officer's question:

Extract 8:13   **(Part of Extract 8:10)**

186   Y: Perhaps it's worth writing to him?

In Extract 8:10, G's answering of a question (L.187) is interpreted as a request for specific information to clarify the current job status of the Queen Margaret doctor. This specific information is eventually supplied by TL (the team leader) on L.189 and confirmed by DR (the team doctor) on L.190. This interactional collaboration provides R with the opportunity to invite team advocacy on L.191. This invitation is taken up by DR on L.192.

Extracts 8:6-8:13 demonstrate how the team 'manages' the trouble of competing professionals. The description of professional inadequacy (psychologist) and physical absence (doctor) conducted in the clinical and practical frames respectively, allows for the team's positioning as clinical experts and advocates.[4] This is demonstrated in the following extract:

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[4] Pfohl's (1978) research also examines how members 'make sense' out of a patient's talk, behaviour or record. This process of 'sense-making' is accompanied by another purpose, that of working 'to accomplish a situated identity as professionals' (1978:94).

Extract 8:14

192 DR: I think the first step is to go round and um — up the interview a bit

193 G: Well — I had a very similar problem a few years ago in Clinton House [hostel]. There
194 was a man in Clinton House who was admitted to, um, Mycroft District Hospital for a
195 physical complaint and whilst he was there he had all these delusions and he was really
196 bad, and he lost his foot — well, he was losing his toes and the — the — because of his,
197 er — his Consultant said because of his poor quality of life we're not willing to do anymore.
198 His legs could drop [off] because he refused to consent to operation and I had really sort of
199 to push a lot, and in the end — [Dr] Threlfall at St. Magna's said he'd take him to a
200 Psychiatric ward but before he was transferred, he died. I think, you know — I think it
201 was a lesson

On L.193 of the extract above, G takes the turn made available by DR and tells a 'second story'. This supports the intention to intervene (cf. Sacks 1992, Vol. I). Reinforcing DR's utterance on L.192, G offers an example of bad practice, or the consequence of failing to act quickly enough. This failure to act is reported to have resulted in a client's death (Ls.193-201). G's second story as 'moral tale' creates an opportunity for agreement or refutation. Ls.200-201 constitute a 'lesson'. In this sense the case account is not simply a moral tale. It represents an exemplar of good practice and distinguishes the work of the team from that of other professionals.[5]

In Extract 8:15 it is the medical ward approach which is being contrasted with the MHT approach.

Extract 8:15

202 Y: Mm, yeah

203 R: That's a cheerful story G!

204 [GENERAL LAUGHTER]

205 R: Thanks for that

206 [FURTHER LAUGHTER]

207 G: Well, you know, it's really about the medical ward's — approach

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[5] Pfohl (1978:94) states that: 'In appearing expert, members "discovered" syndromes and symptoms of clinical significance that the non expert would simply bypass'. Here, Pfohl is referring to 'written language strategies' for appearing expert in keeping with a more legalistic setting than that of MHT practice.

G appeals to the team's common knowledge of the medical ward approach — 'Well, you know', L.207 (cf. Extract 8:36, L.109). The implications of *not* acting characterise this approach as inadequate. This invites comparison with the MHT's approach which is characterised as expert.

The process of 'distancing' and frame interaction not only defines team expertise and its professional boundaries. It also defines the *specific* accountability of other professionals in conditions where the overlap of roles is more problematic, as in the case of social work. This possibly reflects Sheppard's observation that CPN and social work roles have much in common but are 'characterized by significant differences of emphasis' (1990:81).[6]

In the extracts which follow, the bureaucratic and legal frames are used to manage the particular trouble of working with Social Services. The client in question has been assuming responsibility for his two young step-grandchildren in the absence of their mother. A temporary arrangement has become a semi-permanent arrangement as the mother shows no signs of returning. The MHT do not see this situation as appropriate or satisfactory as the possibility of child sexual abuse is inferred. The problem for the *team* is that child protection is not their primary concern. If they continue to provide mental health care for the client, they have to extricate themselves from any accountability for the welfare of the children. The frame utilised to discuss the custodial arrangements of the client's step-grandchildren is the bureaucratic. This is demonstrated in the following extract:

Extract 8:16

139 CPNC: I wonder if one of the Social Workers up there is dealing with him?

140 G: Well — according to him — he thinks Greenton has written to Wilmington [Social
141 Services] you know

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[6] Barrett (1996) describes the social work role as being 'hybrid' and 'less clearly delineated' than the doctor's or the nurse's. This creates 'ambiguity' and 'role blurring' (1996:62).

142 CPNC: I mean — yeah — John [Social Worker] — is he working at that level with him about
143   what he wants?

144 G: He said — in desperation — he went to look for him, and this has really caught them
145   [Social Services] by surprise as well

146 CPNC: Right

147 G: And then, John Curling went to approach his Team Leader in Greenton 'cos

148 CPNC: Bruce something or other

149 G: That's right — and I think that's when Greenton said: No — they will not take
150   responsibility for the children

Extract 8:16 (previous page and above) describes the bureaucratic muddle in which the client is enmeshed. It constitutes a picture of Social Service ineptitude and incompetence. The client's social worker is under the impression that Greenton Social Services have written to Wilmington Social Services about the client's situation. This has not been followed up by any action (Ls.140-141). There is no clear picture of the role taken by John Curling, the client's social worker (Ls.141-142). Greenton Social Services are reported to have been 'caught . . . by surprise' by the client's situation (Ls.144-145). G describes how the social worker approached Greenton Social Services (L.147). The response was a refusal to accept responsibility for the children (Ls.149-150). The upshot of this negative description of Social Services is CPNC's invitation to the team to discuss the *implications* of the failure:

Extract 8:17

151 CPNC: And this is why John's involvement will stop?

In the next extract, G takes the turn made available by CPNC's utterance. In Extract 8:18, his utterance on Ls.152-153 serves to construct an area of doubt around the social worker's degree of involvement with the client, Desmond:

192

Extract 8:18

152 G: Well — I think John will still be interested to work with Desmond. I haven't really got an
153   idea yet — you know — 'cos he was meant to ring me this morning and he hasn't

Whether or not the social worker chooses to continue linking with the client is uncertain as he was expected to make a telephone call to G that morning but failed to make the call (Extract 8:18, Ls.152-153). This dismal construction of professional incompetence functions to distance both Social Services and the 'competing' social worker. It creates a space for the MHT to fill as experts and advocates. It is HU, the team's own social worker, who takes the turn made available by G's utterance:

Extract 8:19

154 HU: [muffled] his past history. Surely somebody, somewhere, should at least be monitoring
155   his involvement or his care of his children

In the extract above, HU's raising of the question of responsibility for the children's care is put in terms of the client's 'past history' (L.154). This sophisticated manoeuvre redefines the client as conventional/pre-theoretic (McHugh 1970). His past psychiatric history serves as a constraining factor in any judgement of his actions. Following Dingwall and Murray this places the client in Category 'C' where he will be accorded treatment which is rehabilitative rather than punitive (1983:136). Because of the client's reconstituted pre-theoretic status, HU is able to appeal to the team's expectations of Social Services and its perceived responsibilities towards children at risk (Ls.154-155). G takes the next available turn (L.156):

Extract 8:20

156 G: Well — Desmond

In Extract 8:21, HU takes the next turn (L.157) following G's brief intervention. This, in effect, points up the inappropriateness of the present arrangements as the client has

previously been described as vulnerable (Extract 8:19, L.154). HU's utterance on L.157 represents a continuation of her rhetorical utterance on Ls. 154-155:

Extract 8:21

157 HU: Which Greenton should be — Greenton has a responsibility — has a duty to monitor —
158   and at least get somebody round to find out what exactly is going on and get some
159   clarification and some background information — the history of where these children came
160   from and how they got in his care and how long he's been with them — and then take it
161   up with Bruce and say: Well — you've got to get them — you know — you've got to do
162   something. You've got to take them back[7]

G takes the next turn, providing HU with a continuer:

Extract 8:22

163 G: Mm

Nobody takes up the next available turn which is marked by a pause (L.164, not shown). It indicates a trouble in the talk which is demonstrated by a change of frame to the legal. Frame change here has a special function. It enables team construction of other professionals' actions in terms of the legal constraints of social work as Extract 8:23 demonstrates:

Extract 8:23

165 HU: But Greenton's probable *fear* is that they don't want to be lumbered with them *indefinitely*
166   — but then, that's something they have to set boundaries in [   ]. But the children are
167   on their patch at the moment, so they have a legal obligation to do something [pause].
168   Because then — what would the position then be if these children came to harm — then
169   Greenton *would* be responsible because they knew the situation and didn't act on it

HU's utterance in Extract 8:23 defines Greenton Social Services as having a statutory obligation for the children's well being. Her utterance (Ls.166-167) in this context allows for the inference that she is alluding to the Children Act 1989. Part III, Section 17 states that Local Authorities have a statutory obligation:

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[7] HU, the team's social worker, is the chief protagonist throughout this case. This points up a difference with Barrett's (1996) research in which he states that 'at the level of case formulation', it is psychiatric knowledge (rather than nursing or social work knowledge) which is displayed as being dominant (1996:41). This possibly reflects differences in the two settings. Elsewhere, Barrett states that 'context is the hallmark of social work' (1996:65).

'to safeguard and promote the welfare of children within their area who
are in need' (1989:12).

By describing the non-negotiable obligation incumbent on Greenton Social Services with regard to the children , HU's utterance defines the team's accountability (Extract 8:23, L.167). It also distances the possibility of Greenton's involvement in the *client's* care. The upshot of this reinforcement of Greenton's responsibilities towards the children is the area of doubt it sets up regarding the client. The next available turn is taken by CPNC who reformulates the question she originally posed in Extract 8:17, L.151:

Extract 8:24

170 CPNC: I supp — I suppose what I was trying to get at was that — I just wonder who is the most
171   appropriate person to be involved with this man? You know — to be primarily involved?

CPNC's utterance in Extract 8:24 (above) provides for the team's possible involvement in the case. It produces the 'plausible inference(s)' that the MHT are the professionals of choice for the client's care (cf. Silverman and Jones 1976:152). Competing agencies have been distanced by downgrading their actions. Such actions are constrained by the legal imperatives of social work practice. Distancing here 'works' to define areas of professional accountability. Greenton Social Services are constructed as the children's advocate and the MHT as the client's. This accentuates the team's professional identity and characterises its difference from 'others'.

This difference in the characterisation of 'others' and the MHT can be located in much of the casework talk and is marked by contrasting pronouns. Apart from defining expertness, Atkinson (1995) suggests that the use of contrasting pronouns in casework also has a general function. This he describes as:

'marking an important transition in the career narrative, separating
the pre-consultation from the post-consultation phases' (1995:103).

195

Evidence of both uses is found in MHT data, but particular attention will be given to the post-consultation phase when considering Extracts 8:39-8:43. I will now examine team use of contrasting pronouns in more detail.

8.3 Contrasting pronouns in team work

Team use of contrasting pronouns is demonstrated in the following extracts. In Extract 8:25, DR's utterance on L.132 constitutes correct practice when managing other agencies who inappropriately move depressed clients. 'We're' (L.132) represents the MHT's collective expert opinion. It contrasts with the 'otherness' of the resettlement officer — 'you're', L.132 — who will not be able to fulfil her role of resettling the client. 'She' represents the resettlement officer on L.135. The officer is characterised as 'difficult to negotiate with' (L.135). She is also characterised as a figure of fun who is reported to be more interested in pictures of nursing homes (L.136) than in what the team has to say about the client ('while you're saying something', Ls.136-137). By constructing the resettlement officer as 'limited' in terms of mental health skills, the MHT constructs itself as experts:

Extract 8:25

| 132 | DR: | So wh — what we're going to be saying is: Sorry — this is one person you're not going to |
| 133 | | be able to re-settle this month |

| 134 | R: | Jane was amenable to that though wasn't she — isn't she? |

135	CPNC:	She was — yeah — but she's still very sort of — she's very difficult to negotiate with
136		'cos she just keeps showing you more and more pictures of these homes while you're
137		saying something and: Oh — look at this. Look at the garden

Extract 8:25, Ls. 132-133 are the upshot of a previous description of the activities of a resettlement officer who is constructed as a figure of fun:

Extract 8:26

125 CPNC: Well, I don't know if they have — I don't know whether it's one particular Resettlement
126   Officer

127 R: Well, I think the pressure is on them to/they haven't made their figures this month and they
128   have to

129 CPNC: To get people out — to get their targets you see

130 R: Jack runs around Hope House saying: Have you got your resettlement figures/have you got
131   your resettlement figures — you know

The doctor's use of the pronoun 'we're' in Extract 8:25, L.132 signals solidarity with other team members.[8] It represents team identity. It also marks an outcome which all team members can support (cf. Griffiths 1997:73). His use of the pronoun shift 'we're' to 'you're' on L.132 functions to differentiate the MHT from the Resettlement Officer.

In Extract 8:26, R describes the Resettlement Officer in derisory terms (Ls.130-131). The description ties back to CPNC'S opening description of the Resettlement Officers where the word 'snatch' on L.13 (not shown) is used to describe their activities in resettling hostel clients on the south coast. In a sense it is part of an ongoing description of the Resettlement Officers which caricatures them as figures of fun. They are constructed as being incompetent and of not working in the best interests of the client.

Such 'character work' constructs the MHT as experts. The upshot of this is DR's taking of the turn made available by R on L.131:

Extract 8:27

132 DR: So wh — what we're going to be saying is: Sorry — this is one person you're not going to
133   be able to re-settle this month

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[8] In Barrett's Ridgehaven study, he states that an 'egalitarian style of talking' touches on the 'human' aspect of the case so bridging differences between professionals (1996:96-97). In Chapter Four, footnote 9 he compares this to the use of the 'we' orientation in Strong (1979:82-83) which is used 'to create a shared consensus amongst colleagues'.

But R takes the next turn and creates a trouble in the talk by suggesting that Jane, one of the Resettlement Officers, is positioned to take part in the client's future care:

Extract 8:28

134 R: Jane was amenable to that though wasn't she — isn't she?

CPNC 'manages' R's attempt to upgrade the status of the Resettlement Officer by taking the next turn and re-characterising the Officer as a figure of fun:

Extract 8:29

135 CPNC: She was — yeah — but she's still very sort of — she's very difficult to negotiate with
136   'cos she just keeps showing you more and more pictures of these homes while you're
137   saying something and: Oh — look at this. Look at the garden

This additional character-work functions to distance the Resettlement Officer. It is marked by an episode of loud background laughter[9] from the whole team on L.138 (not shown). The upshot of this episode of laughter is the taking of the next turn by the doctor (Extract 8:30, L.139 below) whose commentary on the Resettlement Officers plays with terms more associated with a primary school environment. His utterance constitutes a further indictment of the competence of the Resettlement Officers' work:

Extract 8:30

139 DR: Do they get a minus two if somebody comes back?

140 CPNC: No — no they don't, no — because somebody could come back the next day — so — if
141   they/somebody they sent out like — Tom Leland would be a good example — somebody
142   who keeps being sent out. He could be sent out three times a month to different places —
143   and that's *three* people being resettled. It's an absolute crazy way

The doctor's utterance on L.139 creates an opportunity for team members to produce a negative commentary on the skills of the Resettlement Officers. CPNC takes the turn

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[9] In this MHT case, it is the Resettlement Officer who is being ridiculed as part of the process of 'distancing'. In Barrett's study, team members make jokes about those they exclude, 'underscoring the process of exclusion' (1996:85). 'Bureaucrats' are also lampooned. Barrett observes that conflict arising between core professions cannot be dealt with in this way as all are indispensable team components (1996:85).

made available by the doctor and 'floats' the descriptor 'crazy' (L.143) in the context of the Resettlement Officers' administrative abilities. CPNC's description is endorsed by R who takes the turn made available by her utterance:

Extract 8:31

144 R: Like Tom Leland, you go off and then come back

This is heard as an authoritative eyewitness account by Y, the team's Housing Officer. Y takes the next available turn which constitutes a summary:

Extract 8:32

145 Y: They actively want people like that

In Extract 8:32 above, the use of the pronoun 'they' (L.145) differentiates the Resettlement Officers from the MHT. Y's utterance constitutes an invitation to comment on the motivation of the Resettlement Officers. The turn made available is taken up by CPNC:

Extract 8:33

146 CPNC: So, in fact — it's not an issue to them whether someone will settle there; that doesn't
147   matter. The fact that they just then — go there, that's all

Her utterance on Ls.146-147 signifies a shift of frame from the clinical to the ethical frame. This functions to distance the competing agency still further and refocuses team debate on the issue (L.146). The change of frame provides a description of resettlement practice as unethical. In this sense it represents the underpinning philosophy of the team which is constituted in difference. It *is* an issue for MHT practice to support single people with mental health problems and to secure them accommodation. The reflexivity of CPNC's utterance in this cultural context suggests a contrast with the ethics and competence of resettlement practice (Garfinkel 1992). It

works to downgrade the skills of the Resettlement Officers (L.147) and constitutes the MHT as experts and advocates.

Extract 8:34 also demonstrates 'expertness' through the use of contrasting pronouns. In this extract the team is constructed as experts in the assessment of mental health. It debates the issue of deliberate self-harm. It deals specifically with supporting hostel staff who are regularly confronted by such behaviour.

Extract 8:34

107   R: 'Cos I'm wondering is that — yes, I think there's a need for a generalised kind of teaching
➔ 108   maybe; it's highlighted a need for them to learn about it. This is a very specific instance
109   where — [we're] looking for something, you know, p'raps more urgently than that — I
110   mean, I wonder whether it would be good for somebody — but not you [the doctor] to be
111   talking to them about what it's like to be working with somebody specifically like Peter
112   Scrivener, um — and how you deal with that — that sort of anxiety and the fear of what
113   he might do. I think sometimes you're saying to people: Well, if he cuts himself, you
114   know, he cuts himself

115   Y: Yeah

116   R: You know

117   Y: But I — I also think that not all of them — I mean — some of them — not all of them,
118   understand what — the — the — the issue about someone being depressed who, you
119   know, [is] threatening to kill themselves and who, you know, is actually ill, and therefore
120   being in hospital is a very positive thing 'cos, I mean/I don't — so I think, I suppose in a
121   way [laughing], I think it would be good for them to actually hear about, you know, what
➔ 122   the difference is and why — understand why with somebody like Peter we're not actually
123   rushing round getting him to hospital because we're actually — 'cos they're, you know —
124   some of them are still saying to me: He's still suicidal — and he's not

Hostel staff are characterised as not having the skills to differentiate between routine antisocial behaviour and that resulting from major mental illness. This has resource implications for the team. The possibility of providing teaching for the hostel staff is broached in terms of helping them to make 'reasonable decisions' on the shop floor, and to discriminate 'what to take from scarce resources' (Ls.98-100, not shown).

The use of 'we' and 'them' to do teamwork is also demonstrated in Extract 8:35:

Extract 8:35   (Part of Extract 8:34)

107 R: 'Cos I'm wondering is that — *yes*, I think there's a need for a generalised kind of teaching
108   maybe; its highlighted a need for them to learn about it. This is a very specific instance
109   where — [we're] looking for something, you know, p'raps more urgently than that — I
110   mean, I wonder whether it would be good for somebody — but not you [the doctor] to be
111   talking to them about what it's like to be working with somebody specifically like Peter

In the previous extract, the 'I' of L.107 is aligned to the need for teaching. It contrasts with 'them' on L.108 who are the objects of that need. This differentiates the MHT from the hostel staff. The use of 'we're' on L.109 (Extract 8:36, below) marks the boundary of the team's involvement and constitutes its professional expertise in difference:

Extract 8:36   (Part of Extract 8:34)

109 R: [we're] looking for something, you know, p'raps more urgently than that — I

R's appeal to the team is signified by the use of the pronoun 'you' in 'you know', L.109 (cf. Extract 8:15, L.207 and Extract 8:38, Ls.121 and 123, amongst other examples). But R qualifies this appeal — differentiating the team's role as teacher from the doctor's predominantly clinical role:

Extract 8:37   (Part of Extract 8:34)

110 R: ..... I wonder whether it would be good for somebody — but not you [the doctor] to be
111   talking to them about what it's like to be working with somebody specifically like Peter

R's use of 'I' but 'not you' on L.110 defines the boundaries of work within the team itself which effectively excludes the doctor from anything but a medical role (cf. Atkinson 1995:103 and Barrett 1996:58-59).[10]

In the next extract, the team ('we') are constituted as knowing which client behaviour to respond to and which not, whereas the hostel staff are constituted as not being able to discriminate:

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[10] Barrett refers to the chief source of nursing power as 'proximity' (1996:58). Nurses have 'collective proximity to patients' whereas psychiatrists work from more of a distance as they define patients 'in terms of deep case space' (1996:59). According to Barrett, nurses can claim 'privileged knowledge' of 'the surface of the case' (1996:59).

Extract 8:38 (Part of Extract 8:34)

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121   Y:        ..................... I think it would be good for them to actually hear about, you know, what
122            the difference is and why — understand why with somebody like Peter we're not actually
123            rushing round getting him to hospital because we're actually — 'cos they're, you know —
124            some of them are still saying to me: He's still suicidal — and he's not
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In Extract 8:38, Y's utterance on L.124 leaves open the possibility of agreement or refutation from other team members. R takes the next available turn and his 'No' on L.125 (not shown) supports Y's formulation of the client's behaviour.

Extracts 8:39-8:43 again display team competence. In addition, they also demonstrate the more general function of contrasting pronouns in casework identified by Atkinson (1995). This is — as transition markers separating pre and post-consultation phases (see pp.195-196). In Extract 8:39, 'they' (L.222) refers to the Queen Margaret's staff who devised the client's original care plan incorporating a vitamin level check:

Extract 8:39

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222   M:    Actually they put on on — on his plan that they should check his vitamin level, but that
223          was, that was a week before. When I got there, it hadn't been done

224   DR:   If he's got Wernicke's, they should just treat it. I mean, Thiamine is fairly innocuous sort[11]
225          of stuff anyway

226   G:    So you'll go with M
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In Extract 8:39, hospital staff action is located in the past, 'a week before' (L.223). This represents the pre-consultation phase of the narrative. The pronoun 'I' (L.223) represents the team's Social Worker, M. This contrasts with, and is indexically linked to 'they' (L.222). It signifies a temporal change which marks the post-team consultation phase in the narrative. DR (L.224) takes the turn made available by M's utterance on L.223 — and demonstrates MHT medical expertise. G takes the next available turn (L.226) and invites DR's advocacy in the form of accompanying M to the hospital to assess the client. Extract 8:39 overall demonstrates a well orchestrated

[11] Refer to Extract 8:9, footnote 3.

collaboration by three team members who represent social work, medicine and community psychiatric nursing respectively. The device of contrasting pronouns 'tracks' the case narrative temporally from the past (Ls.222-223) to the present (Ls.224-225) and on to the future (L.226)

In Extract 8:40 it is the Queen Margaret's Hospital staff who are being differentiated from the team:

Extract 8:40

222 M: Actually they put on on — on his plan that they should check his vitamin level, but that
223   was, that was a week before. When I got there, it hadn't been done

The pronouns 'they' (L.222) and 'I' (L.223) signify a 'difference' with M, the team's social worker, who distances herself from the care given to the client by the Queen Margaret's staff. The doctor takes the turn made available by M (L.223):

Extract 8:41

224 DR: If he's got Wernicke's, they should just treat it. I mean, Thiamine is fairly innocuous
225   sort of stuff anyway

'They' and 'I' (L.224) are contrasting pronouns which mark medical omission in this context. 'They' refers to the Queen Margaret's hospital staff. 'They' put the client on a plan to check his vitamin levels (Extract 8:40, L.222), but failed to follow this through (L.223). 'They' should treat the client's condition (Extract 8:41, L.224). The contrasting pronoun 'I' on L.224 is indexically linked to the preceding construction of the Queen Margaret's staff. It refers to the team doctor whose utterance works up the Queen Margaret's characterisation and constitutes *his* expert knowledge. G takes the next available turn:

Extract 8:42

226 G: So you'll go with M

In Extract 8:42 (previous page), G's utterance begins to constitute advocacy. It signals the team's intention to send its own doctor with the team social worker to assess the client. Ls.227-238 (not shown), constitute a team debate on what might be the most likely diagnosis. This culminates in DR's formulation on L.239 of the following extract:

Extract 8:43

239 DR: Could just be alcohol and *that* we can sort out when we go to see him

In producing case accounts then, team members are also producing themselves by downplaying other people's expertise. They are formulated as methodically rule-guided. Their social characterisation is that of 'expert' in the field of mental health care with others as less expert. They have a collection of owned experiences which defines them as the MHT. However, there can be alternative or competing collections of experience. Exactly how the team selects its collection of experience will be examined in the next part of the analysis.

8.4 Client biographies - team biographies

It is incumbent on team members to select the *specific* collection of experience which serves the needs of the team. Blum and McHugh (1971) refer to this as a 'selectional problem'. It includes:

> *'a search procedure for deciding the relevance of one biography . . . as*
>
> *compared to other possibilities'* (1971:106).

This 'search procedure' utilises both client and other agencies' characterisations.[12] By so doing, it also constructs a biography of the team. This biography constructs the team's identity as 'expert' in the field of mental health care. Client characterisations are 'up played' or 'downplayed' to endorse that version of the client account which best facilitates the team's formulation as 'expert'.

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[12] Byrd (1981:43) states that in 'doing motives', a relation is produced between 'some concrete socially problematic event and a past set of experiences by positioning an orientation (motive) which could produce the current state of affairs'. In MHT work, motives are invoked when client actions are being debated. Through such processes, the team itself is being subjected to evaluation as experts in mental health care.

In the following two extracts the team demonstrates its 'expertness' by downgrading Queen Margaret's Hospital, a competing agency. The case is presented by M, the team's social worker:

Extract 8:44

3   M: Um [pause] — has anybody got any ideas about housing for somebody that I, uh, have been
4   seeing? His name is Fred Turner and he's, um, fifty three year old and he's — at the
5   moment he's in Queen Margaret's Hospital in Corrington with ten per cent burns. Um —
6   he's been in about a month. He was doing quite well up till about two weeks ago when he
7   stopped eating and drinking so he's become very weak and is being fed through a tube up
8   his nose and [he's] also become incontinent so he's got a bag as well so he's not, um, in
9   any condition to have anyone come and do an assessment in Community Care, um —
10   though Ben and I referred him to Ashvale Social Services

In the extract above, M constructs the case in terms of client vulnerability and physical ill health. This also makes the client vulnerable in terms of housing as he is deemed to be 'not, um, in any condition' to be assessed for community care purposes (Ls.8-9). This establishes need and locates a context for assembling a case on homelessness. Having established a 'need', the vulnerability factor is reinforced by a further element — that of 'other agencies' — in particular, the MHT's negative perception of other agencies' ability to cope. In the following extract, M constructs a version of the client's mental state which differs from that offered by the staff of Queen Margaret's Hospital:

Extract 8:45

16   M: we're quite sure he has mental health problems but what they are — we don't know —
17   and on his report when I was there the Psychiatrist had put down Wernicke's
18   Encephalopathy, um, but the additional things the Psychiatrist had said like — short term
19   memory problems — don't apply to Fred. He went to the Drummond Centre for at least
➔ 20   seven mornings — was [   ] and was quite good at orientating himself — you know —
21   timewise — date, time, and stuff like that. Recognises me and other people as well. But
22   — there is a sense that he's not understanding everything you say to him, and even though
23   you might not understand his nonsense, you do get a sense of him responding appropriately
24   when he's well

In the extract above, M downplays the hospital psychiatrist's diagnosis (Ls.18-19) and 'up plays' her own account of the client based on an earlier interaction. This constructs

the client as 'orientated' (L.20) and 'responding appropriately' when well (Ls.23-24). This throws doubt on the psychiatrist's diagnostic abilities and privileges the team's working relationship with the client over the hospital's — the team having known him for a longer period of time. It would appear that providing a context involves the utilisation of two major elements. These are:

(1) establishing client vulnerability (as discussed in Chapter Five)

(2) constructing client 'need' in terms of this vulnerability. This is coupled with the perceived inability of other agencies to *serve* this client need.

In Extract 8:45 (Ls.20-24) M's characterisation of the client suggests some potential for improvement. Also, M's use of 'orientation' as a criterion of assessment points up a difference with the Queen Margaret's team (L.20). This differentiates the team's account from that of other agencies who do not appear to recognise this potential or who do not use the same assessment criteria. In other instances, competing agencies are downgraded as part of the process of distancing. Frame changes are an integral part of this process.

8.5 Constructing an economic frame

Although the team's identity is constructed as 'expert' in the field of mental health care it does not use the clinical frame alone to accomplish its work. It uses a variety of *different* frames which reflect changing circumstances (Strong 1979:12). For example, the bureaucratic frame with its concern for efficiency, is present in *all* case accounts from the very beginning of the fieldwork period (October 1992). Appropriateness of referrals, boundaries of work and the effective use of resources are ongoing features of members' talk. However, economic contingency achieves greater prominence in data gathered in the later fieldwork period (April 1993) — three years after the passing of the NHS and Community Care Act (1990)[13]. A new economic

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[13] NHS and Community Care Act (1990). Chapter Seven of the Secretary of State's document which preceded this legislation (Caring for People — Community Care in the Next Decade and Beyond, 1989) outlines initiatives for supporting people with a mental illness. From 1991 'all district health authorities will be required to have instituted in collaboration with social services authorities, a care programme approach for such people' (p.56). Para.7:22 (p.58) identifies the need to explore practical steps to assist homeless, mentally ill people to obtain the help they need. Chapter Eight makes various proposals for developing community care and records past expenditure but says little about future financial resourcing.

frame makes its appearance in team talk during the later phase of recording, but not on a consistent basis. This new frame incorporates the team's traditional concern for resources with a 'sharper' concern for managerial accountability. Case extracts will now be used to demonstrate how the gradual emergence of the economic frame is reflected in the talk. It is a new frame which is not discernable in earlier case talk. It represents the team's response to the changing contingencies of its work. Constructing this frame involves active work for the team. In her psychiatric outpatient study, Byrd (1981) too notes that economic pressures influence the clinic's search for suitable clients. Throughout the duration of her study, clinic staff were hoping to establish a second geographical area of coverage (1981:113).[14]

Extract 8:46 which follows shortly describes a familiar dilemma for the team — that of working conterminously with high dependency hostel staff. Such staff are perceived as being unable to plan care effectively for more acutely disturbed clients. These are described by the Team Leader as being 'the new breed' of client. The case account from which the extract is taken dates from October 1992. The team's reported fear is that the hostel staff's inexperienced involvement in care planning will be detrimental to the client's rehabilitation. The client might also lose her place in the hostel. This has resource implications for the team. The action plan which is proposed and eventually implemented is one of *sharing* responsibility for the work:

Extract 8:46

56 TL: I suppose — just thinking about what you might do is, sit down with the key worker
56   [pause] and share what you have in terms of, you know, plans and, um, objectives — what
58   you're both doing with her, and see if you can come to some sort of comp, unified plan.

The bureaucratic frame is being used in Extract 8:46 above. There is the suggestion that there might be 'some sort of comp[romise]' or 'unified plan' (L.58) as a means of managing the client's care. Such a contractual arrangement between the team and the hostel staff might also reduce conflict when boundaries of work are ill-defined.

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[14] Economic pressures differ in the two studies. In the MHT study, members differentiate between catchment area and non catchment area clients (see 6.4). In Byrd's study, staff are actively trying to expand their work.

The next extract dates from the end of October 1992 and is a nice illustration of what has been said before about case appropriateness (see 6.2 on 'appropriate' and 'inappropriate' clients). The client in question is already receiving care from a community mental health team in another catchment area. She is housed in bed and breakfast accommodation. Several MHT members have been approached by this agency in what is perceived as an inappropriate effort to transfer part or all of the client's care to them. A CPN from the West Greenton CPN service has contacted both Y, the team's Housing Officer, and G, a team CPN:

Extract 8:47

36	G:	The impression when he first rang me was that — it's actually that they're dealing with
37		her type of thing — mental sort of health, perspective — in that she's — she's known to
38		the Service. But because she was in a bed and breakfast, it would take longer to

39	Y:	Well, he said to me: I don't know why they've referred her to us; we've done a housing
40		assessment. And I said: I can't say I'm worried about her

41		[LOUD LAUGHTER]

42	Y:	right — you know [ ] — let's be optimistic, you know. Let's keep the possibility that
43		they're concerned about her mental state and they think she needs assessing

44		[GENERAL LAUGHTER]

45	G:	I suppose my worry is, as I said to Y, my immediate concern is that she'll probably get
46		pushed onto HU [a colleague], who falls in between the two teams. I suppose the other
47		thing is really I'm, I'm — the first time round [ ] it might well be that she's known to
48		them and is a bit difficult. She's been in bed and breakfast for nine months now

The bureaucratic frame is used throughout Extract 8:47 in which the team distances itself from the West Greenton CPN service. In this extract, G's and Y's interaction is the upshot of Y's previous definition of the issue on Ls.33-35 (see below):

Extract 8:48

33	Y:	the issue *really* was/is, well, that um — he was saying: Ah [ ] keeps referring people to
→ 34		us you know, and we can't really deal with all their referrals. I think he was actually hoping
35		we would take her on. That's a whole area of work that we'd

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In Extract 8:47, Ls.36-43 constitute 'doing inappropriateness'. They provide the grounds for Y's earlier decision presented in Extract 8:48, L.34 (previous page).

The West Greenton team are already 'dealing with her type of thing - mental sort of health, perspective' (Extract 8:47, Ls.36-37). She already has accommodation in a bed and breakfast facility (L.38). MHT intervention would not be appropriate in this context. However, Y's utterance on Ls.42-43 (Extract 8:49) leaves open the possibility that the MHT might yet be approached as a resource by other teams:

Extract 8:49   (Part of Extract 8:47)

42 Y: right — you know [   ] — let's be optimistic, you know. Let's keep the possibility that
43   they're concerned about her mental state and they think she needs assessing

The turn which follows is marked by general laughter (refer to Extract 8:47, L.44). It provides an opening to voice the implications of this possibility. In the extract which follows, G takes the turn made available by the laughter on L.44:

Extract 8:50   (Part of Extract 8:47)

45 G: I suppose my worry is, as I said to Y, my immediate concern is that she'll probably get
46   pushed onto HU [a colleague], who falls in between the two teams. I suppose the other

In the extract above, G's utterance displays concern about accountability. HU is the team's own social worker — its own resource. But her line of accountability is not clearly defined as she 'falls in between the two teams' (L.46). This constitutes a practical trouble for the team's work. It is eventually managed by G's referring it up to the team's doctor:

Extract 8:51

50 G: [remark addressed to Doctor] I thought I'd let you know because it's possible that you'll
51   be chatting to Tony at some stage [laughing]

In the previous extract, 'Tony' (L.51) refers to the Consultant on the West Greenton team. The solution reached provides for future contingencies in the team's work.

Sometimes frames interlock as evidenced by the following case extract dating from April 1993. In this extract the bureaucratic and economic frames 'fuse'. The client in question has had frequent, non-productive meetings with the team and has led an unsettled existence for a period of eighteen months. He has used all the health and social services offered in the area whilst moving from place to place. Added to this, staff hoping to engage him have experienced difficulties in maintaining a working relationship with him once contact has been made:

Extract 8:52

140 R: There's no real problem with the bloke — 'cept the last time Rhoda tried to see him —
141   I'm sure she'll give a full presentation in due course — but I think he's going to slip away
142   anyway

In the extract above, the client is presenting a management difficulty because he is wilful (Ls.141-142). TL, the Team Leader, takes the next turn:

Extract 8:53

143 TL: Realistically, he's not going to get an assessment anyway is he — 'cos he just doesn't fit
144   the sort of criteria

TL's utterance is constructed in bureaucratic terms. The upshot of his utterance is a change of frame to the economic frame which is laminated onto the bureaucratic:

Extract 8:54

145 R: This you don't know prior to criteria, so — if you see by Downtown's — he's in hospital
146   — he's entitled

R's utterance on L.146 ('he's entitled') focuses on the economic implications of the case.

In Extract 8:55 below, K takes the next turn, accounting for the client's entitlement to a Community Care assessment in terms of his mental health status:

Extract 8:55

147 K: He's got a mental illness

R takes the next available turn interpreting K's utterance on L.147 as insufficient grounds for an assessment:

Extract 8:56

148 R: They haven't got the same sort of criteria as say — Ashvale have. It's all done on

HU, the team's social worker, takes the next turn and reiterates the policy on assessment for community care:

Extract 8:57

149 HU: If it's in hospital, they have to see the person, um, I think it's within

150 G: A week

151 HU: One day, and then the assessment has to be finished within seven days. You have to
152   have/in order to establish where they're going on discharge

In the extract above, HU's utterance is framed in the economic/bureaucratic frames which interlock (Ls.151-152). R takes the next turn:

Extract 8:58

153 R: So, the difficulty is not to attempt to get the assessment. It's about who's going to pay
154   for

R's utterance in Extract 8:58 (above) constitutes a formulation of the problem which is completed by HU:

Extract 8:59

155 HU: Wherever he goes after assessment

The 'new' issue here for the MHT is how to manage a client whose mental health status is difficult to define and whose behaviour and motivation is wilful. A new frame emerges to deal with this practical trouble in the team's work. This frame is the interlocking bureaucratic/economic frame. Its emergence and utilisation is the team's response to the 'wilfulness' of the client which keeps breaking through the account. It illustrates how team members engage in *continuous* interpretive work. In the context of this particular case, the team's use of the interlocking frame is a 'remedy' for a locally constituted 'trouble' (cf. Peräkylä 1989 which identifies the use of the psychological frame to manage a locally constituted trouble).

A further extract from the same case demonstrates the emergence of a purely economic frame. The client is described as not cooperating with health and welfare agencies in an effort to rehabilitate. He does not see his situation as being in any way undesirable. Following team discussion, the client is defined as conventional/theoretic and is given Category 'A' status (Dingwall and Murray 1983:135). The 'punitive treatment' which follows this is the withdrawal of MHT intervention on his behalf, though not of advocacy. This is encapsulated in a general statement made by G who voices the team's 'collective' reservation about becoming involved in the client's care:

Extract 8:60

234 G: I mean, just as a general point — I mean, I'm very pessimistic about taking any kind of
235   responsibility for James, for that kind of housing and funding. Whether this should be [ ]
236   by the DHSS[15] [   ] — instead of waiting for things to really get bad before we let them
237   know

The reluctance to accept responsibility for housing and funding is very much an economic concern. It is a perspective which is brought to the team's attention in the newly-evolved economic frame. It successfully deals with the issue of resources but

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[15] Department of Health and Social Security.

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does not solve the problem of meeting the current welfare needs of the client. The upshot of G's utterance is a change of frame to the bureaucratic. It signifies an attempt by R to manage this trouble in the talk:

Extract 8:61

238   R: Yeah, I mean — we have to wait until the assessment's been made in this case — I think,
239   you know, wait until somebody is sent — not ours — sort of arguments begin, you know,
240   and then we can say

It is unwise to speculate about the full body of R's utterance on L.239 (Extract 8:61) as the quality of the tape was poor at this point but it appears reasonable to suppose that R might well have said:

Extract 8:62

239   R: you know, wait until somebody is sent [a referral] — not ours [to make a decision]

The inference here is that bureaucratically speaking, the client is not the team's responsibility until it has received an official referral to assess his mental health status. The next turn is taken by the doctor:

Extract 8:63

241   DR: Sounds like — good sort of case history [approach]

In the extract above, the doctor's utterance on L.241 endorses R's suggested action plan in Extract 8:61, Ls.238-240. Such motivational talk in this particular context celebrates the success of clinically-orientated but efficiently minded bureaucracy which needs to justify what it does in hard economic times. His summing up of the team's decision provides for the continuance of its reputation as experts in the field of mental health care. It also leaves open the question of advocacy which the MHT might or might not provide in the future. K, a CPN, takes the next turn:

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Extract 8:64

242 K: Mm

K's utterance is an invitation to continue. It is taken up by the doctor:

Extract 8:65

243 DR: That's not — entirely untypical for some of our [clients]

In a sense, the whole interactional sequence which begins in Extract 8:61 and carries through to 8:62, 8:63, 8:64 and 8:65 demonstrates 'caring professionalism' (cf. Gubrium and Buckholdt 1982). The case is something of a milestone in the history of MHT casework as it represents one of the earliest examples of a client who is not directly engaged by the team.[16] It is a relatively unique decision for the team to make. It requires some additional 'justification' from the doctor who has legal accountability for the work of the team and its practice (Extract 8:65). In effect, it becomes a new 'rule' — one which still has to be fully incorporated into the institutional arrangements of the team's working culture. R takes the next turn:

Extract 8:66

244 R: Mm

The upshot of his continuer is a question from TL, the Team Leader:

Extract 8:67

245 TL: You'll be making a referral to the Central [Team]?

The next turn is taken by R with his utterance:

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[16] In the case of the wilful client, the MHT utilise an interlocking, bureaucratic/economic frame to manage a practical difficulty. In Byrd's (1981) study, staff use specific 'buffering' techniques to manage practical difficulties. 'Under reporting', for example, screens out 'both undesirable and desirable clients' (1981:108-9). The use of the 'no appropriate openings' rule is used to rule out clients who are deemed to be treatment risks. Staff selectively apply this rule. This is possible because there are separate sets of criteria for 'inclusion and exclusion' (1981:109). In addition, use of the 'holding system' establishes 'short term waiting lists of low risk patients' (1981:115).

Extract 8:68

246   R: We've made a referral — yeah

The emergence of the purely economic frame indicates that frames are not static. Team members are working to produce them on a continuous basis.

This chapter demonstrates how the character of the MHT is accomplished through the use of interacting frames. Members construct their identity as experts in mental health care by distancing competing claims to expert knowledge. As discussed earlier in Chapter Six, frame changes are integral to this process. Such changes are continuously utilised to manage troubles in the talk and to construct a team biography of professional expertise. The account is an active collaboration which provides for the rationality of the team's work. In this sense, teamwork is fundamentally a process of 'knowledge work' (cf. Opie 1997).

Chapter Eight overall examines how the team constructs itself as expert by distancing other contenders for client advocacy. I now turn to a closer examination of the team's practical reasoning in order to investigate those processes through which advocacy is accomplished.

8.6 Local practices — the story of the 'sacked caseworker'

The extended extract which follows shortly demonstrates how the MHT manages the institutional dilemma of a client who wishes to discharge himself from care. I refer to this story as that of the 'sacked caseworker'. The caseworker in question is R, a CPN. R reports that a client named Frank resents his weekly visits as he believes R is 'working for the Government' (Extract 8:69 over page, Ls.23-24). The client has requested that the visits stop. The extract demonstrates how advocacy is displayed as an attempt *not* to label the client. However, at the same time, it also demonstrates how members' interactions collaborate to make visible the psychological incompetence of

the client (cf. Holstein 1988:458). The data has similarities with Holstein's (1988) observations and findings in American court rooms during involuntary commitment hearings. Such hearings involve the production of evidence upon which the determination of 'grave disability' is based. The MHT's interactions do not occur in a strict legal environment as do Holstein's.[17] Neither are they subject to the restricted conversational range of a court room. However, both demonstrate my premise that social organization is constituted through interactional practices.

Ls. 19-64, Extract 8:69 have similarities with Holstein's observations on the strategy known as 'letting them hang themselves' except that R humorously shows how 'rational' a lot of Frank's reasoning was. The use of humour also constructs R as a sympathetic teller. Holstein's description of the strategy which is employed by District Attorneys suggests that it allows the client to speak without constraint so that symptoms of mental disorder might eventually appear.[18] This demonstrates how the notion of normality is located inside the individual — glossing over the interactional activity by which it is constituted (1988:472). Such commonsense reasoning is also demonstrated by the MHT but in a more sophisticated and complex way. This will be discussed after the extract. The extract is reproduced at length to allow the reader an overview of members' interaction:

Extract 8:69

19	R:	.... Um — anyway, I saw him this Thursday and his views about
20		what he described as his 'history' were pretty well developed by this stage in that, um, he
21		was very clear that I had the explanation and that I was in fact about to con the information
22		from him but uh — why he was in the position he was in — talking about why people/not
23		understanding why people were getting at him — and that I — was working for
24		the Government, um, which of course I am —

25		[BACKGROUND LAUGHTER]

26		um, and that — you know — I was part of the system — and why had the system treated
27		him in this way. Was it not the system that had actually put him in this position, um —
28		which again [laughing] — is true enough, um — and was basically saying that he saw me

[17] Barrett calls the case discussion a 'form of oratory' (1996:89). It does not appear to have a pre-ordained format and it sounds, conversational. For Barrett, the objective of such oratory is to forge a 'team definition' of the patient, which is turn presages *another* form of case oratory which he calls 'planning management' (1996:89).
[18] This has similarities with Pfohl's (1978) observation that Lima Hospital review teams assume that truly dangerous individuals will reveal their 'lack of control' or 'lack of ego strength' at some point in an interview (1978:108).

29		as an agent, um . . . His — his previous thoughts had been that I'd worked for MI5, um,

29   as an agent, um . . . His — his previous thoughts had been that I'd worked for MI5, um,
30   and that now — no — it wasn't as definite as that. A lot of it/in another way, it was perfectly
31   logical; it was a perfectly logical argument. There was no evidence of thought dis-order
32   although obviously the content of his thought was persecutory in nature — sort of bordering
33   on the delusional and, um — if you want to see it that way. Or you can see it in another way
34   — a perfectly logical argument as to — he was feeling that he doesn't understand why his
35   life has always been such shit, you know. Um — he wasn't able to deal with any sort of
36   explanations that I attempted to give him. He had this feeling that I'd been consulting with
37   some higher officials

38   [BACKGROUND LAUGHTER]

39   which — again — of course, I had

40   [BACKGROUND LAUGHTER]

41   Giles [MHT doctor] and I'd talked to Dr Raymond, you know. But it was quite a difficult
42   interview

43   [BACKGROUND LAUGHTER]

44   because obviously I couldn't deny what was the intention with me. There was an element
45   of truth in all of it. It was *almost* delusional stuff but he wasn't completely off the wall;
46   there was quite a strong basis in reality — and, uh — anyway, this carried on for a while
47   and [   ] he then — I asked him, you know — given how he felt about me — what did
48   he want to do about further appointments, and he — so he — you know — he said: You
49   know — it's up to you — obviously feeling that it wasn't going to make any difference
50   *what* he said

51 DR: Mm

52 R: and I fed that back to him and basically — he sacked me on the spot, and that's that really

53   [PAUSE]

54 DR: For the moment anyway

55   [LAUGHTER]

56 R: It will be interesting to see what happens — whether this will be/I think he was very
57   surprised [pause] — he was quite surprised that that was accepted

58 DR: [That] you — you gave him an option

59 R: Well I — I said to him, you know: What do you want? Well, he said, he felt he didn't
60   have any choice [   ] and, um, so I said — said to him — he said: What will happen if
61   I say I *don't* want to see you? Well — you won't see me anymore. And so he said: Okay.
62   [   ] I left him a week's supply of Sulpiride!

63   [BACKGROUND LAUGHTER]

64   He looked at the bottle and said: What does it mean — avoid machinery?

65   [LOUD LAUGHTER]

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66 R: See whether this, um

67 DR: New régime

68 R: New régime

69 DR: Yeah, quite

70 R: It worked with Bill Todd

In this extract, humour is used as a pre-emptive strike on critics who might say that R was judging his client. The account is treated humorously almost like a joke. There is laughter throughout its telling. As a funny story it is used to do two kinds of work. First, it is used to construct a paranoid client. Second, it is used to construct the teller as someone who does not prejudge clients. The frame utilised in this humorous story is the clinical or psychological. R's utterance on L.20 characterises the client in terms of his own 'history'. This history has previously been constructed in terms of psychological vulnerability — defining the client as conventional/pre-theoretic (Ls. 3-9, not shown). This definition categorises the client as not being responsible for his actions from the outset of the account. Generally speaking, constant ambiguity is demonstrated throughout the team's interaction. For example, R's utterance on L.29 suggests that the client had delusional thoughts about his working for MI5 ('his previous thoughts had been that I'd worked for MI5') — but this is quickly downgraded by the utterance which follows: 'no — it wasn't as definite as that' (L.30). Again, on L.45, R refers to 'almost delusional stuff but he wasn't completely off the wall'. In essence, the story of Frank Hopper as recounted by his caseworker never really 'climbs out of' the clinical frame. Use of this frame functions to define a situation where team advocacy is made relevant. It also ensures that Frank's biography remains that of psychiatric patient (cf. Goffman 1979:86).

What Holstein refers to as 'crazy talk' (1988:461) cannot be totally substantiated in this extract, but an area of doubt is successfully created and maintained through the use of laughter. Constructing diagnostic doubt in MHT casework is a pervading

feature of members' talk and is functional to their work. It is a discursive device similar to that observed in medical discussions, described by Atkinson and others as 'hedging' (1995:122). Following Atkinson, such a device can act as a 'plausibility shield' qualifying the narrator's commitment to a report's credibility (1995:123).[19] In MHT casework I suggest that 'doing humour' in the clinical frame serves an additional function in that it preserves the client in a way that legitimates the team's *continuing* professional intervention.

This is demonstrated in the data in Extract 8:69, L.51 — DR's 'Mm' represents a continuer. This functions to endorse R's utterance on Ls. 49 and 50 which report the client as saying that his opinion will not count. The pause on L.53 creates a space for another speaker, but it is not taken up. DR takes the next available turn (L.54) which refers back to his utterance on L.51. The episode of team laughter on L.55 marks the rule breaking rather than the rule breaker (see p.78) — underlining the client's definition as incompetent (Dingwall and Murray 1983:135). R takes the turn made available by the laughter. On L.56 he reports that the client will be 'very' surprised if he has a real choice. On L.57 this is downgraded to 'quite' surprised as it might also be heard as a commentary on the quality of the professional relationship he has with the client. R's utterance on L.59 is prefaced by 'Well'. This functions to mitigate DR's previous utterance about options (L.58). As Holstein (1988:463) observes in his court room work, commonsense understandings of 'crazy talk', or in this case, implied crazy talk, are regarded as being so revealing that it is quickly terminated when it emerges.[20] This is demonstrated by R's utterance in the following extract. In Extract 8:70, the upshot of the interaction between R and the rest of the team as represented by an episode of collaborative laughter on L.63 is a further episode of team laughter on L.65 (not shown).

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[19] Pfohl (1978:100) suggests that members' practices are guided by practical assumptions 'about the consequences of their decisions'. Team decisions are thus 'carefully worded' as they have a bearing on expert identity. Doing diagnostic doubt is functional to the work of the Lima review teams in the sense that the 'true test of their expertness would come in time' (1978:100).
[20] Pfohl states that after members typify patients 'as presenting a "displaying mode" they quickly move to provide additional documents of his or her "bizarreness" . . . ' The interview is then terminated as it is believed there is no more to be gained 'from hearing more of what a patient has to say' (1978:156).

Extract 8:70   (Part of Extract 8:69)

62 R: [   ] I left him a week's supply of Sulpiride!

63   [BACKGROUND LAUGHTER]

64   He looked at the bottle and said: What does it mean — avoid machinery?

In Extract 8:71, R takes the turn (L.66) made available by the laughter, his hesitation 'um' functioning to allow for a formulation by the doctor:

Extract 8:71   (Part of Extract 8:69)

66 R: See whether this, um

67 DR: New régime

68 R: New régime

69 DR: Yeah, quite

70 R: It worked with Bill Todd

The doctor's formulation is that the situation represents a 'New régime' (Extract 8:71, L.67). R takes the turn made available by DR's utterance and endorses the formulation (L.68). The upshot of R's utterance is DR's substantial concluding of the formulation (L.69). R takes the next available turn which functions to justify this new approach (L.70). The account overall displays the team's rational decision-making (cf. Silverman and Jones 1976). Members' interactions work collaboratively here to produce the context where both advocacy and surveillance are relevant. The team's talk is commonsensical to an extent like ordinary conversation, but it is also institutional.[21] As discussed earlier (refer to pp.215-216), it might not be subject to the strict turn-taking of a courtroom hearing — but a pattern of sufficient order is observable nonetheless. It is through such interaction that the team's work is accomplished. Members demonstrate that they are able to adapt and modify rules to

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[21] At Ridgehaven Hospital Barrett (1996) states that the 'key' of case discussions is in the 'untheorized, common-sense domain' which enables consensus (1996:99).

meet each new contingency, including that of a client who wants to sack his caseworker (cf. Gubrium 1989).

8.7 <u>Conclusion</u>

Overall, Chapter Eight examines how the MHT uses practical reasoning and frames to construct its own identity. This identity is that of expert in the field of mental health care. Other agencies are distanced by the use of laughter. Laughter is also used as a means of preserving diagnostic doubt. This functions to legitimate continuing team intervention. Extract 8:69 demonstrates how members interact in the clinical frame to define a situation where team advocacy is made relevant.

How does this chapter relate to other chapters in the data analysis section of the thesis? Primarily, its relationship is based on the concept of interacting frames. In Chapter Eight, frames expose the client to team knowledge and construct the team as expert. Here, team *identity* is constructed through the activity of framing. Team use of frames is also demonstrated in Chapter Six. This chapter analyses how members draw on a range of different frames to manage threats to the clients' pre-theoreticity.[22] Frames are also used to manage threats to the working practices of the team. Clients too are constructed through the activity of interacting frames.

Chapter Seven analyses framing from the perspective of gender. It demonstrates the flexibility and intricacy of members' use of frames in MHT casework. Like Chapters Four to Six, the documentary method of interpretation is utilised by members, but it is done in a gendered way. Here, members use gender inductively as an interpretive frame to make sense in casework.

Chapter Three also examines the use of frames in the context of opening the case. Clients are characterised as vulnerable in terms of their mental health using the clinical

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[22] In his Ridgehaven study, Barrett (1996) also demonstrates how staff move 'deftly' from one model of illness to another in their negotiations about the meaning of schizophrenia (1996:20).

frame. Clinical frame use functions to construct case appropriateness at an early stage of MHT casework. Data demonstrate that case openings account for client selection and presentation. Competence is assigned to the narrator as the 'teller' of the case (cf. Holstein and Gubrium 1995:19). Framing here enables the production of organizationally known 'types'. It is used fluidly by team members to characterise clients and to organise practical action.

All six chapters analyse how the indexicality of interaction is remedied to constitute MHT casework. Throughout — members continuously and actively collaborate at working with interacting frames. So, the team's local enactment of context is enabled by its utilisation of interacting frames. Following Silverman, context here corresponds:

> *'to that actually invoked by participants'* (1998c:6)

rather than by the researcher.

PART III. CONCLUSIONS

Chapter Nine: Conclusions

The advantage of doing case-study research is being able to change the focus of the research during the course of the study. The researcher is not bound by a rigid hypothesis. This thesis set out to discuss a case study of a community-based interdisciplinary team of mental health professionals who work with homeless people. The aim of the study was to 'unpack' the team's decision-making processes. In a sense, the original research question (ie. how do they do it?) has remained the same. However, emerging analysis of the team's social practices has revealed new knowledge about the *extent* to which client description is an organised social accomplishment. This has generated additional research questions.

Early analysis of the team's decision-making processes demonstrated that members construct the client as vulnerable in terms of mental health and/or homelessness. A charge of deviancy is brought and then debated (McHugh 1970). Data were analysed against a background of changing and laminated frames (Goffman 1974) and local cultures (Gubrium 1989). Emerging analysis suggested that challenges to the client definition of pre-theoreticity ('troubles in the talk') are managed by changes of frame, laminations to existing frames and additional character work.

Using this early analysis, I attempted to construct a model which might be capable of explaining the team's 'deliberating rationality' (cf. Gubrium and Buckholdt 1982). I later abandoned the model. It proved to be of limited analytic value as its rigidity failed to capture the interactional sophistication of members' use of frames. I will now explain what I mean by this.

The team's use of interacting frames is a collaborative social process capable of managing 'troubles' on an *ongoing* basis.[1] However, there are two senses of 'ongoing'. The first is historical time - changes over the years eg. the NHS and Community Care Act (1990). The second, more 'micro' sense, is turn-by-turn eg. openings and closings. This is conversational space.

This second sense was not reflected in the model which did not take account of local practices such as the beginnings and endings of cases. As Gubrium discovered at Cedarview, managing troubles is subject to local construction and transformation (1989:98). Troubles varied with 'organizational rhythms' so demonstrating the second sense of 'ongoing' (1989:103). However, in the case of the MHT, interacting frames did more than manage threats to the client's pre-theoretic definition. Later analysis of the data demonstrated that they were also used to manage threats to the working practices of the team. Chapter Eight for example shows how a new economic frame emerges in response to increasing managerialism and economic accountability in the period following the implementation of the NHS and Community Care Act. This demonstrates how the first sense of 'ongoing' impinges on the team's conversational work.

The original model also failed to uncover members' varied use of specific frames. The clinical frame for example, is sometimes demonstrated in its psychological sense and sometimes in its physiological sense as a means of managing local conditions as team discussion on an inappropriate client shows (see pp.128-146).

However, constructing a model at that stage of the inductive process proved useful later in that it generated new knowledge about the bureaucratic frame as being the frame of consensus. Indeed, analysing an account which was conducted *exclusively* in the bureaucratic frame provided new knowledge about the team's use of the bureaucratic frame to manage the anomalous case (see Extracts 6:49 to 6:57).[2] The

[1] Pfohl's study also examines collaborative social processes which impact on diagnostic procedures. He suggests that identifying such processes may provide professionals with 'a reflexive basis . . . to scrutinize their own behaviours' (1978:7). See 9.5 for discussion on policy and practice implications in the MHT study.
[2] The anomalous client referred to here is the female client who has bed and breakfast accommodation outside of the MHT's catchment area. In effect, she does not meet the team's organizational needs. Cf. Byrd (1981) who states that 'whether or not a client receives treatment depends more upon his or her ability to meet organizational needs than upon individual therapeutic needs' (1981:148).

case of the client in bed and breakfast accommodation outside of the MHT's catchment area constitutes an exception. The clinical frame is not utilised in this case and the organisational record becomes the encompassing frame (cf. Peräkylä 1989:126).

As previously discussed in 6.4, the bureaucratic frame is used in its own right and not as a problem-solver for other frames in such 'exceptional' cases. As Strong reminds us, 'it is exceptions which prove the rule' (1979:228). The organisational rule revealed here is that of *not* engaging with other teams' clients. It also has similarities with Dingwall and Murray's work in accident departments where the bureaucratic frame is used extensively to manage 'trivia' (1983).

Having re-examined the study's original research question, in *this* part of the thesis I will return to its overall aims already described in 1.5. In the context of a small case study, the overall aim of this thesis is to contribute, methodologically and analytically, to the sociology of mental illness and to the discipline in general. Its key objectives are:

(1) to unpack the team's decision-making processes thereby to compare and contrast the study's methodology and findings with critical studies in the sociology of mental illness

(2) to contribute to the sociological literature on frame analysis

(3) to demonstrate how 'theoretical generalisation' in sociology can be achieved from a relatively small data set.

In this chapter, I will assess what I have achieved in terms of each of these aims. I will also outline another area to which I have attempted to contribute: namely, the study of gender.

9.1 Contribution to the sociology of mental illness

Having unpacked the team's decision-making processes in Chapters Three to Eight, I will first compare and contrast the study's methodology and findings with critical studies by Byrd (1981), Pfohl (1978) and Barrett (1996). These three studies are the most relevant as they are all case studies in the sociology of mental illness which utilise the concept of 'frame'.

In 1978, Pfohl wrote that 'very little work has been done on the interactional procedures by which psychiatrists or other official labelers produce the categorization of mental illness' (1978:6). His research at Lima State Hospital sought to examine the dynamics of the process through which psychiatric labels are constituted and made public (1978:6). In this sense, Pfohl's aims are similar to those of Barrett's (1996) more recent work at Ridgehaven. In his ethnographic study of Ridgehaven Hospital, Barrett states that his aims are:

> *'to elucidate some of the conceptual structures that make psychiatric work possible'* (1996:40).

In so doing, Barrett analyses what is normally 'taken-for-granted' (1996:40). Like Barrett, but in the context of community care rather than hospital care, this MHT study also analyses what psychiatric professionals 'take-for-granted'. Following Garfinkel, this commonsense reasoning is an 'attainment(s) of members' concerted activities' (1992:10). Case construction then, is 'integrative activity' (Byrd 1981:4).

MHT members use 'selection' and 'typification' to define and re-define clients so that they meet organisational needs (cf. Byrd1981:3; also see Holstein 1992). The MHT's primary organisational need is to find accommodation for single, homeless, mentally ill people. In common with many other human service agencies, the team's

organisational 'requisite' is the need to keep large numbers of clients moving through its agency (cf. Byrd 1981:3). When doing case work, members have to account for their professional actions which 'exposes them to professional risk(s)' (Byrd 1981:4). As Holstein says, actions arising from client descriptions have practical consequences in the 'interactional' contexts in which they are produced (1992:25).[3] This point is examined in more detail in Chapters Three to Eight of the thesis.

In Byrd's research, the 'good neurotic' is the ideal of psychiatric outpatient clinic practice (1981:25). The patients who are able to 'introspect' and 'understand the problem' are the ideal patients of Byrd's study (1981:26). Staff routinely distinguish 'good' from 'bad' patients according to this ideal (1981:26). Demeanor was another distinguishing characteristic of 'good' and 'bad' patients. In addition, outpatient clinic staff did not accept those who were judged to be potentially violent (1981:30). Those who dwelt on physical discomforts ('the chronic complainers') were considered less interesting than those defined otherwise (1981:32). Byrd explains that the dominant ideology of clinical outpatient services is psychotherapeutic.[4] She reports that in her study, the professionals:

'tend to be relatively disinterested in social context or biological underlays' (1981:9).

However, she also adds that the psychologists and social workers she observed had more of a combined psycho-social therapeutic viewpoint than psychiatrists and medical students (1981:9).

In these respects, 'selection' and 'typification' in Byrd's study differs quite markedly from this MHT case study where client demeanor is used by members to construct the case. Also, like the clients in Pfohl (1978) and Barrett's (1996) research, violent

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[3] Barrett (1996) states that management 'is much broader than the notion of treatment. It embraces all aspects of patients' lives' (1996:79).
[4] The preferred type of client in Byrd's (1981) study ie. the intelligent neurotic, is actually the type *dis*preferred in Barrett's (1996) study. Byrd highlights an intake recommendation that a 'bright' and 'put together' psychiatric nurse 'should not be seen here unless by a staff member because of her level of sophistication' (1981:28). It is the personality disordered client who is dispreferred in Byrd's study ie. clients who had 'been in therapy for years, knew the terminology and effectively sabotaged the group' (1981:66). This is also the type of client who is reported to be difficult to manage in MHT practice. Refer to Chapter Five, p.96 of the MHT study for further discussion.

behaviour does not 'exclude' client engagement by the MHT. Neither does 'chronic complaining' about physical discomforts. The 'eccentric' female client of Extract 7:31 for example, represents a MHT case which utilises complaints of physical discomfort to construct the client as vulnerable.

The way in which 'selection' and 'typification' is done by the MHT is altogether 'looser' than that encountered by Byrd in the psychiatric outpatient clinic. In fact, this 'flexibility' is functional to MHT practice as the team's fundamental organisational need is to house homeless clients. Clients are thus referred on to housing and social services in the main, although clinical referral is also done.

In a sense, MHT casework represents 'marginalised psychiatry'. The team's clients are therefore similar to those Byrd identifies as 'patients whom no one else wanted' (1981:40, footnote 6). In Byrd's study, a specialist team was constituted to deal with such patients. This particular team was the only team of professionals in the outpatient clinic prepared to work with potentially violent patients (1981:40). For the MHT by comparison, the clients 'no one else wants' are the very focus of their everyday practice. Assessing clients' mental health status and assisting them with their accommodation needs represents the MHT's professional expertise.

MHT casework is also concerned with dangerousness[5] as part of the process of assessing the mental health status of clients. In this, it has similarities with Pfohl's (1978) review teams' work at Lima State Hospital. Pfohl examines the 'purposes-at-hand' that guide the interaction of team members (1978:8). Such interactions 'thematize(d) operating definitions of . . . mental illness, dangerousness, and psychopathy' (1978:8).

Like the MHT study, Pfohl's research examines members' accounting practices. It examines how members utilize 'typified stocks of knowledge' in their construction of

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[5] Refer to 7.2.

patients within the context boundedness of their work (1978:25). For Lima Hospital review team members, their working context is a maximum secure institution where inmates already have a record of violence. For MHT members, it is an informal psychiatric facility in the community. Both studies analyse how social processes constitute the 'objectivity of psychiatric decision-making' (Pfohl 1978:25). Both find that deviance is accomplished by 'the definitional work of others' (Pfohl 1978:40). However, such definitional work is functionally relevant to particular teams because of their different contexts. Hence, it has different practical consequences for their patients and clients.

Unlike the MHT who utilise a broad range of frames[6], the Lima Hospital review teams operate within a very limited range of frames. These reflect the quasi-legal context of the Lima teams' work. Review team members employ legal and clinical frames. According to Pfohl (1978), members have only six diagnostic categories at their disposal which they might apply to patients already categorised as 'criminally insane'. The decisions teams make about particular clinical labels vary with 'the legal category of a given patient' (Pfohl 1978:99).

In nearly every case, a past history of violence, constructed from surveying a patient's record, is used as an assumption that the patient should be viewed as dangerous. 'Dangerous delusions' are also assumed to be predictive of dangerousness (Pfohl 1978:108). However, assumptions about the psychopathic offender differ from team to team, or within teams, producing differences in patients' 'recommended fates' (1978:119). In this sense, the psychopathic offender might be seen as the anomalous case in Lima Hospital review team work as such patients are not perceived as being amenable to treatment.[7]

Pfohl suggests that the different ways in which members frame their clinical assumptions:

[6] Refer to 6.1.
[7] See 6.4 for a discussion on an anomalous case in MHT practice.

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'are important determinants of what are presented to the court as final
diagnostic decisions' (1978:119).

In Pfohl's study, review team members use 'justificatory' and 'reconciliatory' logic in their theorizing about patients (1978:218). The power of reconciliation, he explains, is that of 'gatekeeping' though which accounts are validated because they are shared (1978:180). Members also transform the decisions they make into 'objective' sounding 'expert findings' through the use of technical terminology (1978:218). Psychiatrists in particular take the opportunity to make use of technical terminology to display their indispensable medical knowledge 'as a status resource' (1978:188)[8]. This is especially so when team discussions focus on the subject of psychotropic medication.

Such 'contingent features' of members' interactions *appear* to be structured (Pfohl 1978:219). Pfohl concludes that overall, members' diagnostic decisions 'may have little to do with the psychiatric troubles . . . of patients' (1978:217). This has similarities with Byrd's findings in her psychiatric outpatient study. Byrd's research also demonstrates that institutional requirements determine staff decisions and client fates (1981:2). In Byrd's context, the institutional requirement is that of matching clients to available treatment openings and its own training needs.[9]

In essence, Pfohl's research examines the social processes by which review team members attempt to predict patient dangerousness. It is designed as a study of members' diagnostic achievement through their everyday, practical reasoning (Pfohl 1978:25). Working definitions of 'dangerousness' for example are narrowed down to only those behaviours which are regarded as being harmful to life (1978:106). Known sex offenders could be detained in a maximum-security institution by criteria other than the 'immediacy' of their perceived dangerousness (1978:106).

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[8] Barrett also testifies to a curious mix of 'technical' and 'lay' language at case conferences. He posits that through its key, 'power is exercised over the team as a whole and the way by which it defined cases . . .' (1996:301).
[9] In MHT practice, finding clients accommodation is the team's primary objective.

As the comparison of the MHT's 'selection' and 'typification' processes with those of Byrd's (1981) study indicates (see pages 227-228), the MHT study also shows that the team's ascription of 'dangerousness' is much 'looser' than that demonstrated by Pfohl's (1978) review teams. This demonstrates how locally enacted social processes become 'local knowledge' and 'local culture(s)' according to their setting (Gubrium 1989:94). In the community setting of the MHT study, such processes are less deterministic than they are in Pfohl's legal context. Most MHT clients have informal status and 'dangerousness' is largely managed outside of an institutional setting. In MHT practice, 'dangerousness' is used by members in client descriptions to justify particular social interventions eg. caring professionalism. These are located in MHT casework and disposal.

Reference will now be made to three MHT case extracts which describe how 'dangerousness' is managed.

The first of these cases is that of the male client from Oakley House hostel in Extract 4:3 who is characterised by the team's consultant as being 'very very psychotic' (L.8) and potentially dangerous as he is in possession of a hatchet (Ls.12-13). DR refers to the client as being 'full of a lot of delusions about people injecting him with PC's' (Ls.8-9). Like the review team members in Pfohl's study, 'dangerous delusions' are also used here as being predictive of dangerousness. Managing the case by placing the client on a section of the Mental Health Act is the treatment and disposal route agreed by the team. This decision preserves the integrity of the team's clinical diagnosis.

The second case demonstrates how managing 'dangerousness' *without* the mitigating factor of mental illness is more problematic. The male client in question is described in Extract 6:4 as one 'who shouldn't be seen alone by any women' (L.4). The inconclusiveness of mental illness creates a trouble in the talk which is managed through team use of the bureaucratic frame which is its main 'problem solver'.

The third case is that of the deluded male client in Extract 7:36 who is reported as being 'dangerous when he's not on medication' (L.132). The case is largely conducted in the clinical frame. This successfully manages the threat of future dangerousness by recommending that the client continue on medication.

In a sense, managing such a broad range of implied or actual dangerousness is more difficult for the MHT than for the Lima Hospital review teams. MHT members are making decisions in a context which has fewer institutional constraints and where referral to the criminal justice system is not a routine option. However, at a practical level, MHT members *do* routinely work with dangerous clients in their everyday practice and they draw on a wide range of frames to manage this contingency. The value of the case study approach in this respect is that it enables the researcher to uncover the 'practical sources of everyday troubles' (Gubrium 1989:96).[10]

Although the MHT utilises a predominantly psycho-social model of care for its work, unlike the medico-legal 'confinement' of the Lima Hospital setting, both studies demonstrate a heavy reliance on the medical model approach[11] to mental illness where dangerousness is a factor. Pfohl states that in his study, social accounts of patient situations are sometimes 'neutralized in favour of psychiatric reasoning' (1978:231). He adds that in most cases, any attempt by the patient to account for his troubles in social terms is 'rejected from the outset' (1978:231). This does not occur in MHT interactions to the same extent. Nevertheless, medical ideology maintains a prominent place in client discussions if a client is perceived as dangerous, or indeed, if a client should want to discharge himself from care (see discussion on Extract 8:69).

Barrett (1996) also notes how staff at Ridgehaven interpret delusional ideation as being indicative of mental illness such as schizophrenia (1996:127), while Prior (1993) argues that 'the problems of mental infrastructure' are 'regarded as falling within the demesne of medical psychiatry' (1993:155). The 'difference' with MHT

[10] Refer to discussion on frame analysis in 9.2 of this MHT study.
[11] See pp.84-85 for discussion on the role of the doctor in MHT practice. Also see Pfohl 1978:196 where the psychiatrist assumes the role of explaining to other team members what the research observers 'really wanted'.

casework is that definitions of mental illness are very vague. They become a new social reality ('social problem') in the context of homelessness through the use of interacting frames.

It is also through the use of interacting frames that the workings of professional power are accomplished. This study's findings on gender, for example, demonstrate how MHT caseworkers use the documentary method of interpretation to 'make sense' in their work (see Chapter Seven).

How power 'works' in professional-patient settings is also an analytic objective for Barrett (1996) in his study of the Schizophrenia Team at Ridgehaven Hospital. He poses the question:

'What transformations are achieved in a person's experience and identity when he or she engages with an expert team of talking, writing professionals?' (1996:2).

Drawing largely on Foucault, Barrett's thesis is that the expression of power results from professional capacity 'to define cases of psychiatric illness' (1996:39). This is marked by professional conflict (1996:69). By utilising ethnographic methods, Barrett examines 'modes of power' which arise from members' commonsense reasoning (1996:105). His study reveals the practical consequences of power for Ridgehaven patients as they are 'distributed' throughout the hospital (1996:105). He compares written accounts with members' oral accounts of patients (1996:2). He links definitions of mental illness to social context by examining the historical and cultural dimensions of schizophrenia (1996:272).

Though much narrower in focus than Barrett's study, this MHT research also analyses contingencies of power through case study means. It demonstrates how an

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examination of the interactional detail of members' practices can reveal fine differences in the way that male and female cases are constituted (cf. Silverman and Gubrium 1994:179). Such detail is analysed in real time, in situ. Unlike Barrett's (1996) study, it does not rely on comparisons of members' written and oral accounts. Members' accounts alone are sufficient for the purpose-at-hand which is to unpack the team's decision-making processes.

In this MHT study, it is demonstrated that actions arise from the descriptions of clients which members produce. Such descriptions serve to justify 'caring professionalism' and other social interventions which are located in MHT casework and disposal. The team's discussion on 'Kim', for example - the female client first cited in Extract 6:16, demonstrates how mental health casework is used to account for social needs in terms of housing. Through members' interactions, MHT casework has the capacity to 'go further' than the hospital-based casework examined by Barrett. Clients' identities are totally transformed through MHT casework so that the psychologically vulnerable person 'becomes' a social problems case. Through client case accounts, members utilise their existing skill of caring for mentally ill people and put it to new ends - that of constructing cases for housing. In this sense, the case account produces 'a distinctive construction of the person' (Barrett 1996:275).

Both studies are concerned with the intended and unintended consequences of professional power although MHT discussions are not as marked by professional conflict as are Barrett's (1996:69). Barrett's study focuses on 'particular ways by which . . . persons are endowed with or divested of subjectivity' (1996:301). This has practical implications for patients as they are relocated:

'across the hospital space from closed ward to community' (1996:153).

Barrett states that this is a 'moral trajectory' resting on the values of 'suffering, work and progress' (1996:156).

The moral trajectory is also a feature of MHT accounts as discussed in Chapter Five. It is an important component in the construction of client vulnerability. Heritage suggests that accountings of this kind provide the conditions for the 'maintenance, alteration or transformation' of particular social settings (1983:129). Such accountings demonstrate the team's collective ability to actively and continuously, produce a consequential context. However, in MHT casework, 'moral tales' are used to construct the case for housing whereas in Barrett's (1996) Schizophrenia Team context they are used to demonstrate the patient's progress from illness to recovery (1996:298). The goal of Barrett's teams is to restore the patient to 'personhood' - 'to the mundane world of everyday social interaction' (1996:280). The goal of the MHT is to find accommodation for single, mentally ill people. What is common to *both* studies is that power is:

'exercised within the domain of taken-for-granted knowledge and practice' (Barrett 1996:300).

I will now outline the similarities and differences of the MHT study compared with the studies of Byrd (1981), Pfohl (1978) and Barrett (1996). I will also summarise the contribution of the MHT research to the sociology of mental illness.

9.1.1 Summary

Byrd (1981), Pfohl (1978), Barrett (1996) and this MHT case study research are all studies in the sociology of mental illness which utilise the concept of frame. All demonstrate how actions arising from client descriptions have practical consequences in the interactional contexts in which they are produced. There are, of course, different consequences for patients and clients which are contingent upon the context in which members practice. All studies demonstrate how locally enacted social processes become 'local knowledge' and 'local cultures' according to their setting (Gubrium

1989). Professional power is accomplished through members' use of interacting frames.

Where the MHT differs from the others cited is in the 'vagueness' of the definitions of mental illness used by team members. It also differs in respect of the more flexible use of frames. This is functional to the team's work. Mental illness becomes a new social reality ('social problem') in the context of homelessness through frame interaction. MHT casework is relatively free of professional conflict. This possibly reflects its predominantly psycho-social model of care at a time when care in the community is well established by comparison with the other studies.

In summary, the contribution of the MHT research to the sociology of mental illness is as follows:

• it demonstrates the interactional sophistication of members' use of frames eg. the clinical frame is sometimes used in its psychological sense and sometimes in its physiological to manage client inappropriateness

• it gives access to members' decision-making as it is enacted, in real time

• it reveals new knowledge about the extent to which client description is an organised social accomplishment

• it provides a preliminary assessment of the local organisation of 'care-in-the-community' in one British setting.

Overall it demonstrates how team members manage 'troubles' on an ongoing basis. It also demonstrates how context is continuously and actively produced.

Having concluded this summary, the next part of the thesis will re-examine frame analysis in the context of MHT casework.

9.2 <u>Frame Analysis</u>

I have drawn extensively on Goffman's (1974) concept of frame analysis throughout this thesis. Indeed, it is the fundamental concept which underpins the study. I have used it to examine the relational dimension of meaning in MHT casework. Data demonstrate how frames are continuously disputed. Members' talk in this sense is situated action as case accounts represent the team's social procedures. Data analysis chapters demonstrate how understandings emerge through members' interpretive interaction.

Following Goffman, the total primary frameworks of a social group constitute its culture. Forming an image of a group's 'framework of frameworks', says Goffman, is to arrive at an understanding of its 'belief system' (1974:27). Central to his analysis is what he terms 'the key' which is crucial to what members *think* might be going on (1974:45). Frame transformations occur to accommodate re-keyings[12] in talk which add layers or laminations to the activity. Such layers are themselves laminated to reveal an inner, complex aspect and an outermost aspect ('rim'). This 'rim' denotes the meaning of the activity in the real world (1974:82). For Goffman, then, the rim of the frame is crucial as it is the point at which the internal activity gives way to the external (1974:249).

Goffman's frame analysis is not restrictive. It is a dynamic concept which opens up variability of meaning (1974:238). Goffman himself describes it as:

'an analytic basis for dealing with ambiguity' (1974:307).

However, its capacity to organise both meaning and involvement does not, by itself, provide an adequate analytic framework to explain how members make sense of taken-for-granted assumptions in their work. Goffman's appeal to the display of the

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[12] Barrett (1996) observes that 'intonation and key' was a striking feature of his audiotape recordings. He goes on to add that 'conversational key was such an unnoticed background feature of the discussion' that he had to 'consciously attend to it' as he listened to the tapes (1996:99). See reference to Geertz (1983:92) on p.15 of this MHT study.

ritual order fails to reveal the rules-which-underpin-the-rules in social interaction. He does not say how the skills and practices employed by interactants can be uncovered, but neither does he regard such skills as trivial.

One explanation for this might be that he did not work with data in the sense used here. Testing out the concept in practice would thus have proven difficult. Goffman worked with invented examples and as a result, he rarely encountered puzzling data.

Silverman writes in his book on Harvey Sacks that Goffman:

'marvelled at the everyday skills through which particular appearances are maintained' (1998a:33)

— but he had little inclination towards the building of grand theory. This could be a second explanation for why Goffman's work fails to reveal how the skills of interactants can be uncovered. This thesis makes no claims for the construction of grand theory either. Rather, it examines the social context of MHT caregiving from within, documenting in fine detail how members' practices are locally constituted (Silverman and Gubrium 1994:194). In this sense, it seeks to make the team's work visible — demonstrating how members make sense of their world.[13] As a means to this end, Goffman's frame analysis was of inestimable value to the thesis in its early stages as it provided the stimulus needed to begin my examination of the use of frames in MHT casework.

However, Goffman's exploration of the ceremonial order crucially 'misses' the indexicality of members' practices. The skills employed by interactants remain largely hidden as a consequence, although, as Strong (1988) reminds us, Goffman recognises that interaction is a joint venture. Schegloff too draws attention to the absence of data

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[13] In a sense, this MHT study helps to address a 'gap' in the sociology of mental illness which Byrd notes in 1981. In her Chicago psychiatric outpatient study she states that: 'there has been little sociological research in psychiatric clinics and to this author's knowledge, no one has reported findings from in-depth observation in clinics' (1981:7). More recently, Barrett's psychiatric hospital study provides an in-depth analysis of how schizophrenia is constituted as 'a diagnostic category and a moral state' (1996:2).

in Goffman's frame analysis and recommends that any consideration of talk-in-interaction should focus on what he describes as:

'the moments, not the men' (1988:100).

In the MHT research, which uses transcripts of naturally-occurring data rather than invented examples or examples from novels, it has been possible to examine the work of frames in practice. Transcripts of naturally-occurring talk have also enabled me to use Garfinkel's (1992) concept of indexicality as a methodological resource rather than as a tacit resource (see Silverman 1993:53). This opened up the possibility of following Strong's suggestion that furthering investigation into the ceremonial order might well be accomplished through ethnographic means (1988:235) - or, as in the case of this research, by using case study methods. Through utilising this approach, I have topicalised members' displayed understandings. Such means permitted me to explore both the 'overt' and the 'covert' sides of members' interaction thereby bringing me closer to what they actually do in 'real time'.

Strong himself used ethnographic means to analyse the ceremonial order of encounters in Scottish Paediatric clinics (1979). I have drawn heavily on Strong's work in this case study research. By utilising methods of constant comparison and analytic induction, Strong found that every doctor was an 'expert' and every mother was 'good'. Representing doctors and mothers in an ideal light reflected wider social values. In MHT casework, I found that every team member was an expert and that all clients deserved advocacy.

Writing later in 'Minor Courtesies and Macro Structures', Strong reiterated the centrality of the 'ritual order' in Goffman's writing (1988:228). He did not see this emphasis as being in any way 'trivial' as it has the capacity to produce 'a separate little world' (1988:231). According to Strong, this little world of the encounter is very

robust and can ignore 'routine trouble' (1988:232) — a view apparently shared by Schegloff who regards Goffman's concept as providing important 'building blocks':

'out of which talk-in-interaction is fashioned by the parties to it' (1988:100).

However, this does not have a general application. For Schegloff, there needs to be more focus on how the interaction 'shapes' the participants (1988:100).

I found Strong's extension of Goffman's work on the ritual order very useful in that it prompted me to re-examine the enactment of the rule of advocacy in the MHT setting (cf. Silverman 1993:50). This taken-for-granted ideal of mental health casework proved to be an analytically profitable field of exploration. First, it revealed Goffman's moral rules of 'relevance' and 'irrelevance'. Such rules underpin the ideal rule of advocacy which is central to mental health practice. It also demonstrated very clearly that team members do not mechanically follow rules[14] but use them to focus upon or ignore matters, even though interactants are 'generally unaware' of such skills (Drew and Wootton 1988). Second, it enabled me to examine in more depth the consequences of members' use of frames. This resulted in the uncovering of the surveillance aspect of their role, the 'covert' side of caseworker interaction.

Through a similar process of constant comparison and analytic induction, I began to notice features of MHT data which were not immediately apparent to me at the beginning of the analysis. I became more sensitized to how members demonstrated an orientation to their institutional identity. I also became more aware of how this institutional identity became oriented to the team's institutional tasks. By focusing on the phenomenon of advocacy, I was able to reveal how advocacy is locally constituted in members' activities (see Silverman 1993:54). I will return to the re-examination of the enactment of advocacy in 9.3 later in this chapter. Before I do this, I will revisit

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[14] Refer to Chapter Five, p.106, footnote 8 in this MHT study.

the original aims and objectives of this thesis and discuss them in the light of its data analysis chapters.

By examining advocacy through members' use of frames, I have been able to take up Peräkylä's invitation to 'explicate' the way in which social-psychological models are used in health care and the circumstances in which such models are applied (1989:131). I posit that, in MHT casework, threats to the team's institutional order are managed by members' utilisation of the clinical (or psychological) frame and by resort to humour (see Extract 8:69). This functions to enable the demonstration of institutional authority through the use of a social-psychological model strongly influenced by medical ideology.[15]

On initial examination, the use of the psychological frame appears inappropriate as the object of the team's discourse is a client of informal status living independently in the community, albeit a residential home. Prior (1993) describes just such a phenomenon in his work on the everyday experiences of psychiatric patients who have been discharged from hospital to community-based care. He points out that, in many respects, their 'world' remains essentially medical. In Frank Hopper's case, his reported desire to be free of caseworker visits is located in the social world. However, the team's response to his request is medical ie. chemical therapy in the form of Sulpiride (cf. Prior 1993:191-192).[16] This points up the team's sophisticated use of the psychological frame to manage the trouble of client identity. Members not only demonstrate the ability to invoke this frame but they also demonstrate that they can draw on a range of different therapeutic models *within* the psychological frame when the situation requires them to do so. In other words, members use what Prior calls 'the lexicon of psychiatric discourse' as a wide ranging resource for case work (1993:191).

In this sense my analysis of frame use in the MHT setting supports Peräkylä's (1989) findings in the leukaemia setting. Both demonstrate how the psychological frame is

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[15] Unsurprisingly perhaps, the two protagonists in Extract 8:69 are a CPN and a psychiatrist both representing disciplines which rely heavily on the medical model. Episodes of laughter on Ls. 25, 38, 40, 43, 55, 63 and 65 indicate the presence of team members *other* than R and DR but such members perform a secondary role. It appears that laughter in this context is actually being incited by R. It is functional to the enactment of a funny story.

[16] Extracts 8:69 and 8:70 demonstrate how the team utilises a biologically based therapeutic model to manage this particular contingency of its work.

used to manage client/patient threats to the institutional order. Where mine differs, however, is in the greater flexibility of the frame which has the capacity to invoke many different therapeutic models of care within it.[17] As discussed elsewhere (pages 128-146), this might reflect the more diverse temporal space in which the MHT operates. But it also points to a more extensive range of routine practices in which the workings of professional power are embedded. In Garfinkel's (1992) words, team members demonstrate that they are not 'cultural dopes'. As Peräkylä reminds us, members are able to use the experience of the client for their own purposes:

'in the specific institutional context in which they work' (1989:124).

In the leukaemia setting, staff utilise a new and broader medical discourse to accomplish their work. In the MHT setting, staff utilise a new and broader psychiatric discourse. This encompasses the physical models of hospital based psychological medicine alongside the social-psychological model associated with non-hospital settings.

Not only does this finding support and extend Peräkylä's work. It also supports Gubrium and Buckholdt's (1982) work in a rehabilitation hospital. In this study, patients who are described as 'old strokes', or 'no hopers' following a stroke, are constructed as having less potential for recovery and to be less likely to benefit from rehabilitation than others. Staff interaction emphasised 'staff knowing best'. Clinical terms related to clinical images for rehabilitation. Progress notes were written to support decisions made and these would be checked with earlier reports for consistency. 'Caring professionalism' was constituted through such interactive practices. It is a phenomenon I have already examined in an earlier part of this study in Chapter Eight, pages 212-215. Through its agency, 'caring professionalism' was constituted to meet a new local contingency, so adding to the team biography of professional expertise. Interestingly, this case represents that of a client who was not

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[17] Extracts 8:69 and 8:70 demonstrate how the team manages the trouble of a shifting client identity through its almost exclusive use of the psychological frame. In addition, they also demonstrate how members use their awareness of caring professionalism as 'evidence' for the moral adequacy of their professional conduct (cf. Peräkylä 1989:125).

directly taken on by the team (see Extracts 8:60-8:68).[18] That it is articulated in economic terms demonstrates how the MHT manages its work against the larger backdrop of welfare rationalization (cf. Simms 1989).

Whether it is through flexible use of the psychological frame or through using an entirely new frame such as the economic, team members demonstrate how description becomes a practical matter. As Gubrium states in his Cedarview Study, where such practical matters are of a policy nature:

'local culture is essentially policy relevant' (1989:99).

This broader issue will be discussed at greater length in the 'implications for policy and practice' section of this chapter (refer to 9.5).

The analysis of the 'sacked caseworker' story (Extracts 8:69-8:71) demonstrates very clearly that, in the MHT setting, commonsense reasoning is a highly sophisticated and complex activity. It also demonstrates the potential and flexibility of the concept of framing. Participants collaborate to shape the 'trajectory of interaction', and this trajectory, in turn, shapes them (Schegloff 1988:100). In this sense, case study methods are a conceptual bridge. Gubrium states that the strength of the approach lies in its ability to uncover the 'moral, yet practical, sources of everyday troubles' (Gubrium 1989:96). As the MHT's managing of the 'sacked caseworker' shows and the 'wilful client' before him, such 'troubles' are subject to 'local construction and transformation' (Gubrium 1989:98). It is through such interactional practices that understandings and usage emerge. Social actors such as MHT members are thus cultural producers rather than cultural products (cf. Holstein 1992).

Like these and all previous analyses in this MHT study, the value of the case study research perspective is that it examines actual practice rather than accounts given by

[18] The case of the 'wilful client' constitutes a local trouble for the team. In this instance, team use of a new economic frame, rather than the psychological, successfully manages the wilful client.

clients. As Holstein and Gubrium observe, so-called open-ended interviews in practice fail to take into account how the respondent's:

'stock of knowledge can shift about in the course of the interview in relation to the role taken by the respondent' (1995:30).

This applies to the interviewer as well of course, or the narrator(s) in MHT casework.

Holstein and Gubrium later suggest that 'actual multivocality can emphasize the richness of meaning revealed' in active interviewing (1995:72). Based on my examination of MHT casework, I also maintain that the 'multivocality' of practical reasoning can be 'captured' through case study research, if only fleetingly. In this sense, the team's social action can be viewed as a performance constituted by and through, many participants. Speaking from a social anthropological position, Hughes-Freeland (1998) points out that such social action cannot be explained:

'without reference to the specific context which frames the action and/or performances' (1998:15).

The performance aspects of MHT work will be discussed more fully when I consider how I might 'do things differently' on pages 255-258.

The major strength of case study methods is that they make possible the understanding of social action as it happens, in real time. I will now move on to discuss the implications of my findings on MHT frame use from a wider analytic perspective.

9.3 The implications of gender

Chapter Seven has already examined gender as an interpretive framework. It demonstrates how members use gender, inductively, to make sense in their casework.

This differs analytically from structural sociology which tends to ignore indexicality. It also differs from feminist approaches which privilege the gendered nature of meaning although Lynne Segal (1988), amongst others, warns of the dangers of such 'essentialist thinking' which reinforces:

> '*the ideas of sexual polarity which feminism originally aimed to challenge*' (1988:xii).

At an ideological level, this polarity, says Segal, supports male dominance and the 'central features of existing capitalist economic systems' (1988:xiii). In this sense, MHT casework as social practice can be viewed as paternalistic.

Closer to my own position, Frith and Kitzinger (1998) have some interesting observations to make on how gender is locally accomplished in their research on 'emotion work'. They suggest that such work should be viewed as a '*participant resource*' which 'ordinary social members' use (1998:1). The members to whom they refer are young women who are talking about sexual negotiations. According to Frith and Kitzinger, the functions of participants' talk are grounded in a particular context. This context may be obscured if participants' talk about 'emotion work' is subjugated to the researcher's categories (1998:2). In a healthcare setting, such as the MHT's, this can have practice implications (refer to 7.4).

In MHT casework, my research findings support Frith and Kitzinger's observations. Analysis of the data demonstrates that client descriptions are used by members to justify particular social interventions. Examining how gender is accomplished in the MHT context reveals how the grounds for such interventions are legitimated.

Examples of casework which demonstrate how the team interactively accomplish gender and legitimate the grounds for intervention have been described in Chapters Six and Seven (see Extracts 6:16 and 7:1).

Both examples demonstrate that gender is relevant to participants and that they use it in social-psychological models of care within a broad psychiatric discourse (refer to 7.4 for discussion). Surprisingly maybe, the workings of professional power in Extracts 7:43 and 7:44 are embedded in a feminist model of care (cf. Peräkylä 1989).[19] A useful comparison might well be made here with purely medical practice. Silverman (1987) makes some interesting observations on professional power and its effects in his work on 'patient-centred' medicine. Speaking about doctor/patient encounters, he suggests that:

'notions of the 'whole patient'. . . are double-edged' (1987:195)

in that the 'science' of the patient has succeeded in extending the range of 'disciplinary power' in medical practice (1987:202). Elsewhere, Silverman (1997) refers to counselling as a discourse of 'enablement' which is implicated in 'networks of power' (1997:224).

In MHT casework, data demonstrate how members use gender to constitute caring professionalism. Caring professionalism is functional to the team's work as it is used to manage local contingencies.

In summary, my findings on gender in MHT casework demonstrate how 'social issues (are) permeated by power relations' (Peräkylä 1989:131). They also demonstrate how MHT caseworkers use the documentary method of interpretation to make sense in their work. This supports Loseke's (1989) shelter work findings. Lastly, they support Holstein's (1992) work on the way that caseworkers use gender in their everyday discourse to meet clients' social needs in terms of housing. This appears to be differently constructed for women. My findings on gender overall thus contribute to more general knowledge of framing and how this works in professional-client settings (Silverman 1993:50). It also shows an *alternative* way of tackling gender which is closer to the 'localist' position adopted by Frith and Kitzinger.

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[19] Fieldwork data from Byrd's (1981) study suggests that staff request particular types of clients which serve the needs of outpatient treatment programmes and staff training. One member is reported to have said: 'We take care of our own . . .' (1981:34). Similar data emerges in the MHT study but here it is much more 'informal'. Choices about taking on particular clients are influenced by personal preference rather than by the need to provide 'balanced caseloads to trainees' which is what happens in Byrd's study (1981:34). Trainees outnumber permanent staff in Byrd's clinic (1981:74). This is not the case in the MHT setting.

Writing about 'localism' reveals the intimate connection between methodological orientations and such apparently given 'facts' as gender. I now turn to methodology.

9.4 Methodological issues

The advantages of the case study method have already been discussed in 1.4. Following data analysis, its major strength as a method is that it makes possible the understanding of the MHT's social action as it happens, in real time. Though the MHT study is narrow in focus, it provides an in-depth analysis of the team's social practices. The strength of the MHT case study overall is that it draws on members' own, local understandings which they display rather than those of the researcher. By so doing, it avoids the limitations of a top-down approach. The findings of this MHT case study might have 'a broader resonance' for other researchers analysing similar social processes in related fields (Seale 1999:41).

In the next sections, I address further methodological issues that arise from my use of the case-study approach.

9.4.1 Reliability and validity in the field

Examining the fine detail of members' commonsense reasoning through tapes and transcripts has been my concern throughout this thesis. However, as Silverman points out:

> *'The reliability of our data should be a central concern of any researcher'* (1998b:111).

This applies to the MHT case study as well as to any other study of social life, whatever the methodological approach. So having considered the contribution of this

thesis to new knowledge, I will now return to the natural history chapter and reappraise it. By so doing, I hope to identify some of the limitations of the analysis and to discuss them in the overall context of this research.

In Chapters Three to Eight, I examined the fine detail of members' practices and demonstrated how members make sense in their work. Unusually, in case study research, I also analysed data backwards as well as forwards, to demonstrate how the upshot of members' interaction is consequential to their work (see Chapter Four, pp.79-84). In this sense, I treated members' practical reasoning as a puzzle. Working backwards and forwards through data can explain how and where 'the puzzle arises and is resolved' (Silverman 2000:131). Hence, knowledge gained is 'theoretically driven' (Silverman 1993:29).

However, one of the limitations of being an independent observer of casework is that the researcher can only be in one place at a time. This presents difficulties of intra-observer reliability. What was made available to me at members' discussions was what they were prepared to let me observe and record in the particular setting in which they met.

Fennell et al (1991) comment on the intimate nature of the relationship between researcher and subjects in participant-observation. They suggest that this very intimacy can be limiting as it 'precludes' certain topics:

> *'which are not normally discussed amongst friends'* (Fennell et al 1991:64).

This depends on the particular mode of research and what is being researched of course. I enjoyed an appreciable amount of openness with MHT members.[20] Nonetheless, there were undoubtedly aspects of their social practices which warranted

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[20] Pfohl's advice to his research observers is that they are to be 'friendly, but not friends; honest, but not open to further involvement; courteous, but not self-revelatory' - whilst in the field (1978:68).

additional caution by members who were fully aware that what they said was being recorded. The issue of 'delicacy' for example has been examined elsewhere (see pp.39-40 and p.166). 'Doing caution' pre-empted the telling of the story of reported client sexual abuse by a psychotherapist.[21] Another aspect of care which invokes additional caution by members is that concerning the management of client confidentiality in the context of HIV infection.

In the situation which follows, the team doctor 'does caution' *after* reporting on the client's HIV status rather than before. As such, it constitutes a 'repair' constructing the grounds for imparting such information in terms ethically appropriate for the record(er). The client in question is the male client described in Extract 5:5.

It is reported that the client underwent an HIV test in the recent past at St. Hilda's Hospital but that he did not return to the clinic for the results of this test. The team doctor tells members that he has read the client's old records which indicate that he is Hepatitis B, but not HIV, positive. However, the client insists he has HIV:

Fieldwork Notes 9:1

DR: He is reluctant to give up the idea [of being HIV positive]. The idea of having HIV is a
        useful tool for engaging peoples' attention

The fieldwork notes above relate to case data which were written but not transcribed at the time of recording on November 13th. 1992. This brief extract of team interaction concerning the client described in Extract 5:5 constitutes a short 'postscript' to the main (transcribed) discussion which took place the previous month (October 23rd. 1992). In the intervening period, the client, given a 'final warning', had lost his place at Oakley House because of volatile behaviour following heavy alcohol consumption. When listening again to this untranscribed data on the audiotape and comparing it to the fieldnotes, a faintly audible repair was discernible which I did not hear when I

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[21] Also see discussion on working with an inappropriate client following Extracts 6:16-6:48.

wrote the fieldnotes. This took the form of an appeal to the special administrative arrangements which are available to doctors when they access confidential data from patient records. These data are now transcribed and the extract is reproduced below:

Extract 9:1

1	DR:	Yeah, he was anxious about HIV because he'd had all these blood tests six years ago. Bit
2		unlikely that [ ]. I got the notes from Broughton. It turned out he had Hepatitis
3		B. He was reluctant to give it up [the idea of being HIV positive]. The idea of having
4		HIV is a useful tool with which to engage peoples' attention [pause] which is
5		understandable. If he turns out [ ]. He had an HIV test more recently at St. Hilda's.
6		I've got a notes release form

Lines are numbered for ease of reading as this short extract only was transcribed from the overall account. The last two lines of the extract (Ls. 5-6) — 'I've got a notes release form' — represents the doctor's retrospective repair. On a more practical point, listening to the audiotape again and transcribing what I heard made me appreciate how much data can be lost when relying on written fieldnotes only (cf. Strong 1979:227). Possibly, more experienced fieldworkers are both swift and accurate in the skill of writing notes but I made some errors as a comparison between the two recording methods indicates. I failed to hear 'with which' (Extract 9:1, L.4) when I originally took the notes as well as the repair.

I have no way of knowing whether or not this repair would be routinely invoked had I not been present but my *impression* is that 'amongst friends' it would be taken-for-granted that the doctor had behaved ethically. This small example demonstrates how merely being in the field may distort it. Following Pollner and Emerson (2001), even 'conventional' ethnographic methods of collecting data can transform 'features of the lifeworld' - so too with case study data collecting methods. In Chapter Eight, I have already analysed how members orient to institutional tasks and identities. It would appear that in the presence of a researcher, this orientation becomes more pronounced. 'Doing caution' in this particular social context is a constitutive practice of MHT

work. The 'limitation' of being an independent researcher, then, can be viewed as providing a useful 'analytic space' in which additional:

'research possibilities (that) can be seen or engineered from any and
every social situation' (Hammersley and Atkinson 1989:103).

However, it would be a mistake to overplay the effect of the researcher's presence on data. This undoubtedly has an effect as I have already discussed in Chapter Two. That team members display their public actions in moral terms possibly indicates that a wider audience is being addressed through the tape (cf. Hammersley and Atkinson 1989:192; also cf. Silverman 2000:149). In this respect, what I have discovered about 'doing caution' in the MHT context could relate to broader issues about the representation of sexual behaviour as a 'delicate issue' in different health care settings. For example, in his work on HIV counselling, Silverman suggests that 'delicacy' is locally organised and that to proceed 'cautiously' is functional to the work of counselling (cf. Silverman 1997:64). Similarly, in Chapter Six, Extracts 6:4-6:9, I have argued that confidentiality is functional to mental health practice so that 'doing caution' is an ongoing feature of MHT casework. However, as my examination of data on highly confidential matters shows, *additional* caution is displayed by members. That the case study approach permits such insights into *how* the team's organization is routinely enacted in its natural setting can be considered a strength of the method (Silverman 1998c:3). It is not the researcher's assumptions about context which are relevant to the situation but members' own (Silverman 1993:8). Matters such as 'delicacy' and 'confidentiality' then are not 'uniform phenomena' in every care context. In MHT practice they have a particular meaning which is embedded in the team's local culture (Silverman 1998b:110).

Documenting the team's procedures through observation and fieldnotes and the transcribing of audiotapes goes some way to addressing the issue of validity and

reliability (Silverman 1998b:111). This data can then be made available to other researchers to see if the findings can be replicated. However, collecting data in this way is very labour intensive. This can be a practical limitation of doing case study work. It makes considerable demands on the researcher through the effort of transcribing. Added to this, in my particular situation, carrying around heavy recording equipment borrowed from my place of work was also constraining. A smaller and more portable tape recorder would not have had the capacity to produce the quality of tape needed in recording multiple voices. As it turned out, the tapes proved adequate for my purposes, but they might have been better. As Silverman says in 'Discourses of Counselling' (1997):

'There cannot be a perfect transcript of a tape-recording. Everything depends upon what you are trying to do in the analysis, as well as upon practical considerations involving time and resources' (1997:28).

As a relatively inexperienced fieldworker, I had not appreciated that there might be easier ways of collecting data. There are no awards for those who choose to gather their own data (cf. Silverman 2000:44). However, there can be *rewards* for the fieldworker. I gained by being able to observe my subjects and by hearing how the group interacted. My chosen method was useful to me in another way too in that only I would hear and transcribe the tapes. This would help preserve anonymity and maintain confidentiality (cf. Silverman 2000:204).

Fortuitously, the heavy tape recorder actually worked to my advantage when I initially entered the field. It was so cumbersome and obtrusive that members' efforts to try and disguise its presence became something of an ongoing joke. This undoubtedly contributed to a more relaxed atmosphere at the beginning which, to some extent, eased the strain of having a stranger on their 'patch'. If members were

uncertain as to how to react to the researcher then talking to me about the tape recorder and its technical attributes fulfilled a necessary social function.

Fennell et al (1991) have some interesting observations to make on 'the initiation into fieldwork' from the context of researching old age. They suggest that doing research is an 'unnatural' social activity as it deliberately violates accepted conventions which allow us:

'to accost strangers in very limited circumstances and to have only brief exchanges with them' (1991:57).

They recommend that in order to manage intrusion into other people's lives, researchers should 'grow a thicker skin' and employ strategies for making awkward situations easier (1991:57-58).[22] However, too thick a skin hampers the very sensitivity a researcher needs in order to work effectively. In my particular case, unease was probably less of a problem for the team than it was for me. The subjects of the MHT study are skilled practitioners who are well able to manage the intrusion of a researcher — especially one who is not a total stranger to them. So many researchers visit the team that several weeks elapsed before any of the members enquired about the kind of research I was doing. This was in spite of the fact that I had explained my intentions as clearly as I could before the fieldwork started.

When the tape was on, members would often nod towards it whilst they were speaking, or even speak directly to it, 'for the record'. This behaviour became less evident as the fieldwork progressed, and was not evident at all when I returned for a second, shorter period of fieldwork in April 1993. Fieldwork notes dating from this period suggest that neither was there a need to renegotiate the rules regarding the use of the tape recorder. Members accepted its presence as before, by and large, but they *did* seek confirmation that I would only put on the tape when they were ready. The

[22] Pfohl (1978) also talks about the impact of observers on members' work. He says that 'following an initial period of mutual orientation, most teams . . . routinely accommodated the field researchers and showed little interest in . . . their presence as observers' (1978:70-71).

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way I addressed their request was to give them the choice of doing this for themselves in my presence. Equally, I might have left the team to do its own recording and then collect the tapes week by week. This would not have been as satisfactory to me as I would have missed fieldnote and observational opportunities.

There was surprisingly little talk from members during the interval in which the tape was turned over. Members waited almost deferentially for recording to resume. However, I observed many instances of 'back chat' whilst the tape was on which were too soft to be picked up on the recording.[23] This suggested to me that the activity of recording was being used as an aid to confidentiality in a sense as off stage conversations were effectively inaudible when the 'main players' were talking.

Difficulty in hearing what was said in such circumstances is a limitation of group recording, especially when additional background noises intrude. However, actually having all the tape recorded data readily to hand throughout the research process was and can be very useful in that it permits the replaying of tapes whenever clarification is needed (see example on pp.249-251). In addition, as Silverman says, tapes and transcripts offer:

'endless opportunities to redefine our categories' (1993:39).

Collecting data in this way is systematic. This increases reliability. It also strengthens claims to validity. I was able to tape-record the team's discussions in the period October 1992 to January 1993, and again in April 1993. By so doing, I tested emerging hypotheses generated by fieldwork and compared these with new data from the later date. In this way I gradually built up an in-depth picture of the team's social world through its own social practices.

Transcripts from the later period demonstrate how team talk reflects legislative and organizational changes in health and social care after the implementation of the NHS

[23] Barrett reports that at case discussions it was 'common for several conversations to be held while the main business continued' (1996:80). He accounts for this by suggesting that at any point, 'any case could be opened up by any participant for a more general discussion' (1996:80).

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and Community Care Act. Collecting tape-recorded data might appear 'selective' in that they represent only a small amount of all the data available in the MHT field. But they have not been 'randomly assembled' (cf. Silverman 2000:234). Together with fieldnotes, they provide not only a systematic method of collecting data but they also offer a richly condensed source of data which lie within the physical and practical scope of a researcher working alone. Theoretical concepts may be developed from such data so 'representativeness' in the same theoretical sense as that applied to quantitative work is not really at issue. Also, findings based on data gathered by similar methods from related fields might be usefully compared. In this thesis, for example, I have drawn on Loseke's (1989) study of a shelter for battered women to examine how the MHT 'does' social problems work.

Overall, this case study of the MHT avoids a top-down approach to the data which is part of good case-study research. However, case studies are difficult to accomplish in a short time span. It is also tempting to use a wide range of theoretical concepts which can sometimes make the analysis unwieldy. I will now explain what I mean by this.

9.4.2 The economical use of concepts

In the early stages of this research, I identified that I would focus on what members were doing. I observed and recorded how they demonstrated their skills. Following initial transcribing, I began to identify recurring instances in the raw data (see pp.47-48). What I found was 'more or less useful' for my theoretical needs (Silverman 2000:78). I eventually rejected one category, that of 'interchangeable roles' because it was not immediately necessary to the analysis. As Atkinson (1995) writes in the introduction to his haematology research:

'*I did not cover all the analytic themes thrown up by my time among the haematologists*' (1995:vii).

Similarly, in my case, I already had a sufficiently 'solid body of original data' and an additional one would not contribute significantly to my enterprise overall (Silverman 1993:39). Each one of the chapters in this study for example might have been developed into a thesis in its own right, although I had no way of knowing this at the start.

As an alternative, I might have worked at the way 'homelessness' is reported in the press for example using newspaper accounts as a data source. Moving slightly away from 'homelessness' as a social category, I could have examined how 'social problems' or 'mental health' are portrayed in television soap operas, or in specialist magazines like 'The Big Issue'. Having already done a Saussurian semiotic analysis of a Welsh heritage park using local newspapers as a data source for my MA thesis, I know from experience that there are less demanding but equally valid ways of gathering data. Conversely, despite what has just been said about the physical demands of the case study approach, doing the research in this way actually lent itself to part-time study in that I could work on small sections at a time. It also extended my existing interest in biographical work which I did as a special option on my Master's course.

Silverman (2000) offers a sensible and very practical perspective on qualitative methodology. He suggests that having chosen an approach, it can then be treated as a 'toolbox':

> *'providing a set of concepts and methods to select your data and to illuminate your analysis'* (2000:43).

My interest in narrative and text for example found expression predominantly in Chapter Five of this study although it is reflected throughout, especially in the use I have made of Paul Atkinson's (1995) work in the haematology setting. Utilising my

existing biographical interest and using Silverman's 'toolbox' analogy described earlier, I will now return to the concept of 'the moral tale' in order to explore how I might write this thesis differently.

Case studies can involve a range of research strategies supported by particular philosophical ideas (Hammersley 1990:15). From this perspective, I could have looked at my original data in a more structural way, analysing them as components of a fairy tale for example. My original categories were certainly flexible enough at the beginning to construct a methodology which would be capable of analysing what Silverman calls 'the formal structures of narratives' (2000:163). My original categories based on members' own categories, can be loosely described as recurring - situational - categories eg. the vulnerable client, distancing other agencies and so on. Such categories would lend themselves to a semiotic analysis for instance where domains of team interaction construct meaning (cf. Silverman 2000:163).

Using the case account overall, but the opening narrative in particular, I could re analyse the transcripts as moral tales or fairy tales. The functions of the 'characters' taking part could be examined (cf. Hawkes 1989:68). Advocacy is the primary function of the MHT and this remains the same throughout the telling of the tale. In other words, it remains a constant element although there are different narrators.

Using principles drawn from Propp's 'Morphology of the Folktale' (1968), Hawkes identifies a limited number of known functions to the tale, that they follow an identical sequence, and that they are homogeneous (1989:69). Viewed as a fairy story then, the team's accounts have a deeply rooted and repeated narrative structure (cf. Hawkes 1989:69).

Crudely adapting Propp's taxonomy, as outlined by Hawkes (1989:69), I might examine the different 'spheres of action' in the case account and produce this list of

performers who are functional to the enactment of the tale:

- the villain (mental or physical illness)
- the-sought-for-person (the client)
- the helper (the narrator of the tale)
- the hero (the MHT)
- the false heroes (other professionals or agencies).

By so doing, the MHT's accounts could be read as epic tales of endurance with the client as 'everyman' suffering all sorts of hardships, but surviving, because of the efforts of the team. Of course, these stories are not literary myths in the true sense, but they have a ritual quality and a mythical resonance which relies on inference to a large extent (cf. Hawkes 1989:45). In a much more vital way, the team's weekly performances are active demonstrations of their social reality rather than a symbolic representation of it (cf. Schieffelin 1998:194). However, I remain very interested in the idea of analysing the same material semiotically. Future research might identify sequences of action which could be analysed using the kind of qualitative computer software which is appropriate to the researcher's needs.[24]

9.4.3 The case study as 'text'

The account which members produce is a collaborative event which has many voices but only a single viewpoint. This constitutes and defines the team's institutional reality.[25] In this sense, the case account can be seen as a testimony to, or documentary record of, the team's expertise and competence. In practice, it is a mixture of the two, part oral and part written — the preparatory notes and the agreed action plan being the only elements of the account which are committed to paper.

Hammersley and Atkinson highlight the importance which such records have 'in certain sorts of social setting' (1989:141). This is an interesting comment and it is one

[24] See Clive Seale's contribution to this area in Chapter Twelve of Silverman's 'Doing Qualitative Research' (2000:154-174).
[25] Byrd states that the process of constructing case accounts serves two major functions - 'integrative activity' and 'strategic ritual'. This 'protects members from both the subjective and objective risks of practice' (1981:4). Elsewhere she states that such processes 'contribute to institutional integrity' (1981:3).

which I will examine more fully when I consider the implications for practice at the end of this chapter. It is sufficient to note at *this* point that decisions made by the team are a potential resource for its everyday work (Hammersley and Atkinson 1989:141).

As mentioned earlier in this thesis, minutes of the team's deliberations were not taken during the meetings although members routinely gave oral presentations from notes prepared beforehand. That these oral presentations eventually achieved written status was through my presence as a researcher (cf. Opie 1997:9). Instead, the caseworker who had presented the case would write a résumé of the agreed action plan when the business of the meeting was over. Shortly afterwards, this résumé would be transferred to a computerised data base. The data base includes a coded category for 'case disposal'. For all practical purposes this data base functioned as the case record (see p.180). Due to reasons explained in Chapter One, I was not permitted to see or record any of the team's written notes. Neither was I given approval to access client details kept on computer.

In Chapter Three, I demonstrated that the opening narrative is an analysable text. In very general terms, this text has similarities with other forms of text — like the life history. Case extracts were used to demonstrate their narrative features and construction. But the opening narrative is *not* a life history as such. It contains biographical material about the client to a greater or lesser extent — but it is a history of the events in the client's life rather than a history of the person.[26] It is also concerned with social processes (Denzin 1989:48).

The accounts are interactionally produced by a *particular* cultural group in a *particular* setting. Like the active interview described by Holstein and Gubrium, the MHT meeting is a 'meaning making' occasion (1995:80). What members actually do and how meanings are constructed and made available through their action, has been the principal focus of this study.

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[26] In Byrd's study, the client selection process is examined. Findings suggest that criteria are based on clients' 'social, demographic and personal characteristics' and that they 'flow directly from staff needs for particular kinds of patients' (1981:5). Elsewhere, Byrd says that client presentations 'symbolically cue(d) the direction of (case) construction' (1981:51).

Case study research also 'works' at a more general, discursive level in that the use and display of case extracts allows the reader to draw inferences from the text (Atkinson 1991:82). In this wider narrative sense, it is not only team members who collaborate. The text itself becomes a collaborative construction between:

> *'the sociologist, the reader, and the social actors represented in the setting'* (Atkinson 1991:82).

Following Atkinson, two new frames emerge in the reading of such texts. These reflect the changing temporal order from 'then' to 'now'. He suggests that the 'then' frame is inhabited by social actors and the researcher and encompasses — 'what happened'. The 'now' is shared by text and reader(s) — the reflection on what happened (1991:83). This is a phenomenon which Atkinson (1995) revisits in his examination of transition markers in the medical haematology setting and one which I have already related to this research in the MHT setting (see 8.3 for discussion on contrasting pronouns).[27] At every level, then, the present 'embeds' the past (Atkinson 1991:83). It would appear that the very act of reading is itself, commonsensical — mirroring the interactive processes through which casework and all social action is constituted.

9.4.4 Summary

The team's displayed understandings have been utilised to construct this thesis. By so doing, I have avoided a top-down approach to the data which is inimicable to case-study research. This has allowed a consistent approach to metholodogical issues. In particular, I have attempted to demonstrate how a single case-study can be both reliable and economical.

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[27] See Byrd 1981:73 for a discussion on the process through which 'therapeutic decisions' are turned into 'administrative' ones. Byrd states that 'the output needs of one subsystem or time frame can be resolved by the input needs of another'. There is not the same sense of 'urgency' about moving clients out of the organisation in MHT practice - possibly because clients are already in the community. Engaging clients is the MHT's primary objective. Moving them on in the system then becomes a wider collaborative effort with related agencies.

In the section which follows, I will suggest how policy interventions may follow from case study explanations of social phenomena based on members' own collaborative practices (cf. Silverman and Gubrium 1994:194).

9.5 Implications for policy and practice

This study examines the 'fine-grained . . . detail of naturally occurring interactions' in the MHT setting (Silverman and Gubrium 1994:195). It attends to the local production and enactment of the team's social practices utilising a 'bottom up' approach. What this approach can do is give access to participants' decision-making as it is enacted. How advocacy and surveillance are enacted for example are local accomplishments in a range of different MHT contexts and activities. They are socially organised, collective acts which do not rest on individual perception (Atkinson 1995:5). They are embedded in the team's organisational setting and are oriented to it. Herein lies a dilemma. Because they are part of the team's 'institutional discourse(s)', they cannot be value free (Silverman 1997:209).

Speaking from a policy perspective, Busfield (1996) states that it is the job of Sociology to 'challenge the belief that psychiatric interventions are value free' (1996:142). But, as Silverman reminds us, this is not an easy task as 'power and resistance' are essentially practical matters which are subject to local contingencies. They cannot always be anticipated (1997:209; see also Peräkylä 1989).[28]

In this study of the MHT, members demonstrate how description becomes a practical and a moral matter through their use of interacting frames. As discussed earlier, situated meanings emerge with each change of frame (see Chapter Six). Like Gubrium's (1989) findings at Cedarview, contingencies of talk have local functions. Hence, local practices are policy relevant.

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[28] Also see Barrett who states that 'by identifying the everyday life of the hospital, with its taken-for-granted assumptions' it is possible to reveal 'the specific domain in which patterns of domination emerged . . .' (1996:104).

Having already examined the contingencies of MHT practice 'microscopically' as it takes place, in situ, I now want to re-examine my findings to see what they might tell us about the institutional frame in which the team operates. In so doing, I will address areas which require further discussion from the earlier part of this chapter. These are as follows:

- policy relevance (pp.233-235)
- constructing the case record (p.225)
- gender implications (pp.244-247).

I will deal first of all with policy relevance.

As discussed in Chapter Five, MHT clients are constructed as vulnerable primarily in terms of their mental health. The possibility of becoming homeless or the practical reality of homelessness, is grounded in this characterisation. This is supported by analysis of MHT transcripts which demonstrate members' use of the clinical or psychological frame in all but one of the accounts transcribed.

The exception is that of the female client who does not fit the team's criteria because she already has bed and breakfast accommodation in another catchment area (Extracts 6:49-6:57).[29] In MHT casework, caring professionalism is enacted through a new and broader psychiatric discourse which is functional to the work of the team and to its institutional order. Use of such social-psychological models of care serve institutional needs. The client who attempted to sack his caseworker for example (Extracts 8:69-8:71) remains a MHT client by the team's skilful use of both the psychological and bureaucratic frames, despite his wishes to the contrary. This represents a moral and practical trouble for the team rather than a problem as reported by the client. Decisions on behalf of the client are made outside of his sphere of influence. The client is not directly party to such decisions about his life and circumstances which then become

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[29] Refer to Chapter Six, p.146 and Chapter Seven, p.180, for discussion on the case record.

incorporated into the case record. That the client has an awareness of the constraints on his autonomy is recounted in the transcript (Extract 8:69, Ls. 59-60).

This highlights an ethical question regarding the function of advocacy in professional mental health care. The team's remit is to assess and monitor the mental health of a potentially transitory population and to liaise with other community agencies in order to accomplish this goal. Working under such an imperative, can team members then be in a position to act as impartial advocates for their client group? Put another way, can it ever be possible to be an advocate in professional healthcare without also exercising social control? One of my earliest recorded observations from fieldwork reflects this dilemma. It is a response given to me by a Psychology researcher engaged upon a quality assurance project. He originally worked with the MHT. I asked the question: 'What do they actually do here?' His reply is given below.

Fieldwork Notes 9:2

P: Engaging clients is the bottom line

This MHT case study focuses on the team's everyday practice. It demonstrates how members do social problems work. Elderly male clients for example are redefined in welfarist terms (see discussion on pages 174-176). Women are constructed as being psychologically and sexually vulnerable and become both the subjects and objects of social problems work (refer to 7.4). Indeed, throughout MHT casework, mental illness becomes a new social reality ('social problem') in the context of homelessness. One of the effects of the team's work is to produce wider surveillance of its client population. The emergence of an economic frame for example suggests that surveillance increases with increasing managerialism in a period of heightened economic accountability. If this process continues in the provision of care for single homeless people, the autonomy of the individual might suffer further erosion.

This of course is not the MHT's immediate practical concern. One acknowledges the difficulty of their role and the social distress which they relieve, or at the very least, help to ameliorate. Taylor and Field (1994) for example refer to homelessness as an ethical dilemma for society and ask, somewhat rhetorically:

'Should people who are unable to look after themselves be left sleeping

rough on the streets?' (1994:152).

Of course, the response to this would have to be 'no'. However, examining what is of practical concern to the MHT is *this* researcher's analytic and practical concern. Perhaps drawing practitioners' attention to the unintended consequences of their work might provide fresh insights into how care is delivered.[30] The 'downside' of such an endeavour is that practitioners might see this in very critical terms. It is not always possible to avoid this but simply giving practitioners access to transcripts and findings without comment might prove the best way of proceeding. This is in fact what I did with my initial findings earlier in the study and they were received with much interest (see pp.40-42).

Silverman (2000) considers how best to introduce research findings to practitioners and asks:

'How can valid, reliable and conceptually defined qualitative studies

contribute to practice and policy by revealing something new to

practitioners, clients/or policy makers?' (2000:295).

In his study of HIV counselling, Silverman (1997) gives professionals access to research which documents the fine detail of their practice. It also acknowledges the structural constraints under which they work. He reports that such an approach is generally well received (1997:223). In a similar way, offering transcripts of the team's

[30] Referring to what she calls 'the dispositional puzzle', Byrd's findings demonstrate that members 'were not . . . employing traditional clinical considerations in making many of these decisions' (1981:141-142). Also cf. Pfohl's findings at Lima State Hospital where review teams 'assumed' that their task for patients in the 'incompetent to stand trial' category was 'more limited than for patients in other categories' (1978:105).

social practices to members could generate discussion and new ideas on promoting advocacy outside of the existing case management system. Independent advocates for example might better preserve the autonomy of the client who is the recipient of care.

At a policy level, the National Service Framework for Mental Health (NSF) which came into being in 1999 has set new national standards for mental health but it is not prescriptive about how these standards are to be achieved. The present time might well prove an innovative one for both practitioners and policy makers involved in service delivery. New initiatives in providing advocacy could flourish in more flexible and localised care delivery systems. The External Reference Group for the NSF for example has developed ten guiding principles to 'help shape decisions on service delivery' (1999:4).

Amongst others, it specifies that service users should be involved in planning and delivering care. It also recommends that services should offer clients wider choice so that independence is promoted. One way of doing this might be to offer clients access to an independent advocate.[31] However, it would be naive to suggest that the 'liberal' discourse, in itself, is any less power-ful than the professional. As Silverman reminds us, the discourse of 'choice' has no meaning except in how it is:

> 'articulated in a given historical and institutional context' (Silverman 1989:40).

As the discussion on advocacy demonstrates, finely detailed but rigorous qualitative studies have much to offer practitioners and policy makers. How the MHT makes decisions, for example, accords with commonsense reasoning. In everyday life, this is so taken-for-granted it is almost invisible. Speaking from a Social-Anthropological perspective, Clifford Geertz (1983) describes commonsense as a 'cultural system' which:

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[31] This is similar to Pfohl's concluding remarks in the Lima Hospital study: as psychiatric opinions are essentially political judgments, they should be "de expertised" 'through a system of public advocacy and adjudication' and 'displayed for public scrutiny' (1978:229-230).

'lies so artlessly before our eyes it is almost impossible to see' (1983:92).

Following Geertz, I suggest that unpacking the MHT's commonsense reasoning can give valuable interpretive insights into the kind of mental health care work society supports (cf. Geertz 1983:93). In this respect, small scale qualitative studies have much to offer practitioners and policy makers. This case study of the MHT points up differences in social and professional roles (see discussion on CPN and social worker roles, p.191). It also examines 'homelessness' as a local phenomenon rather than treating it as a 'monolithic' category which has limited meaning. This could have practical implications for the planning of services so that inappropriate resourcing is avoided. Byrd (1981) provides a word of 'caution' in this respect:

'attempts to alter service patterns through policy decisions are unlikely to be successful unless the nature of the work setting is simultaneously addressed' (1981:148).

The MHT case study is small in scope but the analysis of members' practices is in-depth. This makes it easier to identify what homelessness means to a specific area and community team. It can be the basis for future comparisons with the work of other community teams for example (cf. Bloor and McKeganey 1989:200). Because it shows the detail of how they actually work, members themselves might use it to support their clinical autonomy at policy level. Above all, it reveals the limits of purely theoretical accounts of mental illness. As Silverman (2000) suggests, the 'distinctive contribution' of qualitative research is that it enables:

'the deep analysis of small bodies of publicly shareable data' (2000:43).

I now want to move on to my second consideration which is the case record. Chapter Seven, p.180 states that the computerised case disposal records show only that the team's final decisions accord with their primary objective (also refer to Chapter Nine, p.225). This is organisationally functional to the team's work.[32] In the case of the anomalous client for example (Extract 6:49-6:57), members use the bureaucratic frame throughout, dispensing with the clinical frame entirely. The client's entire experience is transposed into the case record and this organisational record becomes the encompassing frame (cf. Peräkylä 1989:126).[33] Clinical talk is peripheral. This has political and policy implications. Even though the client concerned has not been taken on by the team because she already has accommodation in another catchment area, her record remains with the team. This possibly reflects how clinical decisions have become subservient to managerial and economic decisions in current healthcare practice. Rose and Miller (1992) argue that:

'the nature of the things people are made to write down, is itself a kind

of government of them, urging them to think about and note certain

aspects of their activities according to certain norms' (1992:200).

It is not my intention to examine major changes in economic and political philosophy in this thesis. I will leave that to others better equipped than myself. However, I will point out that perhaps by examining the casework of health professionals through case study research, other areas of academic enquiry can be illuminated.

My third and final consideration is that of the implications of gender. My findings on gender suggest that client descriptions are used by the MHT to justify particular social interventions (refer to 7.4). With regard to female clients in particular, this has a relevance for the training of mental health caseworkers (cf. Silverman 1997:213). Examination of transcripts suggests that there is stereotypical accounting for women's lived experience in MHT casework. This might be a profitable area of discussion for

[32] Cf. Garfinkel's observations about the 'occasional and elliptical' character of psychiatric folder documentation (1992:200-201) in "Good organizational reasons for 'bad' clinic records".
[33] Barrett 1996:119 states that what goes into account making is lost 'through the processes of documentation', giving the documented version a 'factual' quality.

care professionals concerned with women's health. It might also be useful to women's agencies of all kinds who have an interest in mental health care provision and women's social welfare.

Stereotyping affects men too in terms of their behaviour. As discussed earlier in Chapter Seven, men's behaviour tends to be *labelled* as threatening more often than women's (Pilgrim and Rogers 1993:38).[34] Again, this has implications for the training of care professionals.

9.6 <u>Further research needed</u>

Further research that might follow from the findings of this thesis could include:

- further examination of the use of cautious descriptors and 'hedging'

- further research on the function of laughter in professional health practice

- further case study research on the use of the psychological frame in health settings *other* than the leukaemia ward (Peräkylä 1989) and the MHT setting.

Why I have identified these topics and not others needs some explanation. First, I will consider team use of 'cautious descriptors', and 'hedging'. This has been selected because it is a recurring feature of MHT casework throughout the study. It is one which might profit from closer examination in its own right at a future time. In Chapter Eight (pages 218-219) for example, constructing diagnostic doubt was seen to be functional to the team's work. It was compared to Atkinson's (1995) findings in medical discussions where it qualified the narrator's commitment to the credibility of a report (1995:123). In MHT casework, it possibly fulfills an additional function which is that of keeping the diagnosis 'open' so legitimating the team's continuing professional intervention.

[34] In Roy Porter's 'A Social History of Madness', he states that, in the eighteenth century, mental illness such as mania was considered to be 'a masculine disorder' (1989:104). It was personified as a ferocious brute. In more recent times it would appear that expectations of male behaviour remain stereotypic (Pilgrim and Rogers 1993:37). Pilgrim and Rogers state that men 'predominate in criminal statistics' (1993:38). They suggest that this is related to how society judges 'rule breaking' (1993:38).

Elsewhere, I have noted the use of 'cautious descriptors' from anecdotal observation in an A&E department (Chapter Two, p.29). MHT use of 'cautious descriptors' is also an analytic finding discussed in Chapter Three where it is used variously to protect the team's interests when engaging with inappropriate clients[35] and when criticising other professionals.[36] In other situations, it preserves diagnostic doubt in the way described by Atkinson (1995).[37]

I tentatively suggest that such action is an unintended consequence of the larger bureaucratic processes of the welfare state and its increasing professional accountability. Martin Hewitt (1992) amongst others, examines how the welfare state represents what he calls 'the paradoxical forces of juridification' (1992:108). At one and the same time it extends both 'universal democratic rights' and 'legal forms of rationalisation and control' (1992:108). It is not my intention to explore this idea further at the moment but simply to 'log' it as a possible area for future analytic examination. Following Strong and Dingwall (1989) such examination might well take the form of a 'policy ethnography' in which the specific objective would be to examine policy questions through fieldwork and analysis. This idea might be applied to the use of case study research methods as well.[38]

The second and third areas identified as needing further research are those of the function of laughter and the use of the psychological frame in health settings. These are analytic issues.

My work on laughter in MHT casework is very broad in scope. It focuses on 'conventional' Social Science concerns such as social control (Silverman 1993:121). Extract 8:69 with its multiple episodes of team laughter is a clear demonstration of how social control is accomplished in the community mental health setting. Transcripts utilised are adequate for the purposes of this case study of a local culture.

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[35] See Extract 3:9, L.6: 'us working with people who present these sorts of problems'.
[36] See Extract 3:10, Ls.13-14: 'have been sort of . . . 'snatched' by the Resettlement Officers.'
[37] See Extract 5:9, Ls.20-21: 'sort of 'reacting' to perhaps a delusional thing.'
[38] As long ago as 1981, Byrd in America recommended researching into psychiatric clinic settings. At this time, state priority was to develop 'extra-hospital psychiatric care' (1981:7). More than two decades later, Byrd's recommendation remains very pertinent, both in America and in the United Kingdom.

Analysis demonstrates how members respond to their institutional setting. But, as Silverman reminds us, ethnographic work, and by extension, case study work:

'can only take us so far . . . It is unable to answer basic questions about how people are constituting that setting through their talk' (1993:133).

A CA approach to the examination of laughter in the MHT setting would be more micro-analytic in scale. It would also require more detailed transcripts to make such analysis feasible. Rostila's (1992) CA work on laughter in the social work setting for example, is able to demonstrate how a particular communication format between social worker and client has an affiliative function in that setting. CA analysis focuses on the turn-by-turn, sequential order of conversation (Silverman 1993:141). It would be difficult to utilise a CA approach in the MHT setting because of multi-party talk, but *sequences* of talk containing laughter could be identified and examined using this method. The use of CA and videotaping of team laughter might also prove analytically interesting.

And so, to my third and final topic for future research - that of further case study research on the use of the psychological frame in health settings *other* than the leukaemia ward (Peräkylä 1989) and the MHT setting. Potentially, *any* health care setting could be explored through case study means. Such research can shed light on 'macro' structures using 'micro' - interactional analysis as a first step (Silverman 1993:25). Areas such as acute psychiatric wards or surgical units might yield interesting comparisons. How does framing 'work' in such settings where professionals and clients interact? Is the psychological frame used in all health care settings and, if so, how? In many ways, the concept of 'frame' can provide the means of asking 'questions about observational data' (Silverman 1993:50).

Overall, this case study of the MHT reveals the sophistication and complexity of commonsense reasoning and the sensitivity with which team decisions are made. Rather than being a critical account, it demonstrates how *well* an interdisciplinary team communicates. Teachers of communication skills in Nursing, Medicine, Social Services and Higher Education might consider using the case data as an exemplar of thoughtful practice from which others might learn.

Appendix 1:

Abbreviations used

The team had a core membership of nine at the start of my study. As community nurses far outnumbered any of the other disciplines represented on the team, I accorded them separate codes of identification. TL for example stands for 'Team Leader', a senior community nurse. Others are represented as follows: CPN2, CPNC, G, R, J, PH and T. K is a non-permanent CPN member attached to another community team. I employed no particular logic in the selection of identity codes. Some are fairly obvious as with the choice of OT for the Occupational Therapist. Others denote the first or last letter of the member's real name. Where the member's name was unknown to me, as with the team Social Worker for example, a combination of letters was utilised based on the member's physical appearance. The team member in question had long hair which she wore pinned up — hence, 'hair up' (HU). Her successor is referred to as M in some transcripts. The surnames of clients most commonly derived from place-names unconnected with the catchment area from which they came. I have retained clinical abbreviations where they appear in the transcripts in order to remain as faithful as possible to the practitioners' talk (cf. Atkinson 1995:13). For example, GU is used rather than 'Genito Urinary'.

Participating membership was increased by up to five members on occasions due to the attendance of nursing students on clinical placement and/or visiting CPN's from related community teams serving the same catchment area. P, a psychology researcher engaged upon quality assurance work, also visited the team in the early weeks of the fieldwork period. The MHT did not have a psychologist amongst its number but drew upon the resources of the local Trust hospital when this expertise was required.

Appendix 2:

Simplified transcription devices

um	See whether this, um	Speaker hesitation of approx. 1 second
—	Yeah — exactly	Speaker pause of approx. 2 seconds
[pause]	name [pause] are you?	Speaker pause of approx. 3 seconds
[long pause]	Monkton [long pause]	Speaker pause of approx. 4 seconds
[BACKGROUND LAUGHTER]		Description of team activity. Capitals denote louder sound relative to surrounding talk
[PAUSE]		Denotes pause in possible turn-transition point
[LONG PAUSE]		Longer delay in uptake of turn. Capitals denote a hiatus between speakers or a break in a long sequence of talk by the same speaker
[SIDE 2]		Represents second side of audiotape. Capitals denote that tape has been turned over ie. serves as a secondary heading

[approach]	good sort of case history [approach]	Words in brackets are possible hearings by the transcriber
[ ]	time round [ ] it might well be	Empty brackets indicate that the transcriber could not hear what was being said
?	did you speak to her yesterday?	Represents speaker's upward intonation as in a question
-	myxo-myxodematous	Slight, speaker hesitation
/	I don't think/they probably would think	Speaker re-phrasing or correcting where not used to indicate repeated utterance
[Social Services]	has written to Wilmington [Social Services]	Bracketed words describe and explain what precedes them
[Social Worker]	John [Social Worker]	Bracketed words describe the professional role of the person invoked by the speaker
[laughing]	Tony at some stage [laughing]	Indicates that the speaker is laughing as (s)he speaks
. . .	when you can sp . . .	utterance trails off without being completed

' '	'special relationship'	Inverted commas denote that speaker's utterance is slow and deliberate for emphasis
was	if there *was* a crisis	Italics denote stress via louder pitch
→	→155	Arrow pointing to line number in transcript refers to analytical or methodological point under scrutiny in the accompanying text
Hm or Mm		Continuer
Hmm or Mmm		Denotes a longer continuer
[the doctor]	you [the doctor]	Bracketed words refer to the member represented by the preceding pronoun
[name of home]		Actual name withheld to maintain anonymity
:	he said: What will happen if	Colon denotes the start of speech reported verbatim by the speaker
:	R: They haven't got	Colon following initial(s) denotes the start or continuation of an utterance by a particular speaker

Appendix 3:

Manchester Score Sheet (part of Manchester Rating Scale)

CLIENT NAME .... DATE ....

Symptom Rated	Reason for Rating		Score
Depressed Mood			
Anxious Mood			
Elated Mood			
Flattened Affect			
Incongruous Affect			
Motor Retardation			
Motor Excitement			
Coherent Delusions			
Hallucinations			
Incoherence of Speech			
Irrelevance of Speech			
Poverty of Speech, Muteness			
Disorientation			

Side Effects

Tremor

Rigidity

Dystonia

Akathisia

Difficulty in breathing

Other - please specify ....

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[1] Heading adapted from Prior (1993), p.214.