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AN EXPLORATION AND DEVELOPMENT OF THE KNOWLEDGE  
FOUNDATIONS OF SOCIAL WORK, WITH PARTICULAR REFERENCE TO  
MENTAL HEALTH AND COMPULSORY ADMISSION ASSESSMENTS

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**AN EXPLORATION AND DEVELOPMENT OF THE KNOWLEDGE  
FOUNDATIONS OF SOCIAL WORK, WITH PARTICULAR REFERENCE TO  
MENTAL HEALTH AND COMPULSORY ADMISSION ASSESSMENTS.**

by

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Sheppard, M. (1992) Client satisfaction, brief intervention and interpersonal skills. *Social Work and Social Sciences Review*, 3, 2, 124-150.

Sheppard, M. (1993) Theory for Approved Social Work: the use of the compulsory admissions assessment schedule. *British Journal of Social Work*, 23, 231-257.

Sheppard, M. (1995a) Social work, social science and practice wisdom. *British Journal of Social Work*, 25, 265-93.

### 5. BOOKS.

Sheppard, M. (1990) *Mental Health: The Role of the Approved Social Worker*. Sheffield. University of Sheffield Press.

Sheppard, M. (1991) *Mental Health Work in the Community: Theory and Practice in Social Work and Community Psychiatric Nursing*. London. Falmer.

Sheppard, M. (1995) *Care Management and the New Social Work: A Critical Analysis*. London. Whiting and Birch.

These are submitted separately.

STATEMENT OF WHERE AND WHEN THE STUDY AND RESEARCH WERE  
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All research was undertaken in Plymouth.

Sheppard, M. (1990) *Mental Health: The Role of the Approved Social Worker*. Sheffield. University of Sheffield Press. December 1987 to December 1988.

Sheppard, M. (1991) *Mental Health Work in the Community: Theory and Practice in Social Work and Community Psychiatric Nursing*. London. Falmer. December 1987 to May 1989. .

Sheppard, M. (1992) Client satisfaction, brief intervention and interpersonal skills. *Social Work and Social Sciences Review*, 3, 2, 124-150. April 1988 to February 1989.

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## ABSTRACT.

This submission seeks to establish the case that this corpus of work makes a significant and original contribution to a central problem for social work as a profession: the status in relation to practice of its formal knowledge base. This issue has generated intensive debate, with some claiming a central place for formal knowledge in practice and others a more peripheral position. The debate is inconclusive, but evidence suggests that social workers do not generally use theory in practice. This has necessitated recourse to a 'subconscious assimilation' thesis, but evidence from the main research studies is inconclusive, because of the absence of a comparison group for social workers: it was not possible therefore, to claim that their characteristic processes of making sense were distinctive.

Two central problems provide the focus for this thesis: the extent to which formal knowledge is reproduced by social workers in the conduct of their practice, and given the range of conflicting and growing knowledge forms available to social work, principles by which this knowledge could be more closely and overtly related to practice. The first of these was analysed by a comparative analysis of the practice of social workers and community psychiatric nurses, drawing upon the ideas of the occupationally based reproduction of knowledge in practice. The second involved the development of the theory of emergent understanding and social science based assessment schedules, using the exemplar of the development and evaluation of the Compulsory Admissions Assessment Schedule.

A central theme is: that formal knowledge is reproduced by social workers in their practice, and that in order to understand this, and further developments in the theory-practice relationship, it is important to assign a central place to meaning. Two key issues emerged in the examination of practice: the occupation based development of meaning involving particularly the knowledge content of training and the nature of the activity - social work - itself, upon which this knowledge is focused. Both entail issues of meaning: how practitioners 'make sense' of the 'stuff' of their practice, and the nature of that activity (social work itself). The development of further principles and methods for relating formal knowledge more overtly and closely to practice was based on three key dimensions: the nature and limits to social science knowledge (based on a Realist approach), what such knowledge is being applied to (social work) and the way in which meaning is created - how humans characteristically make sense. The ways in which social

workers may bring formal knowledge to practice, therefore, involves the knowledge, its focus and the ways in which practitioners may relate these together. The use of social science as a basis for social work involved a recognition that to maximise its relevance it needs to be, as far as possible, consistent with the nature and purposes of social work. This is the basis for the development of three concepts underlying practice led theory: the practice paradigm of social work, the principle of convergence and the principle of adequacy of fit. Two developments of knowledge forms were proposed: one focusing on *process* issues, the Theory of Emergent Understanding, and the other focusing on the *product* of research, Social Science based Assessment Schedules, both of which encapsulate the elements of practice led theory.

This work seeks to make a major contribution in an area of first rank importance. It establishes for the first time, that social work possesses a distinctive form of practice consistent with its formal knowledge base. This is evident in terms of the distinctive psychosocial domain of social work, in which interpersonal skills have a major part. In the process this work draws upon a number of concepts from occupational and educational sociology: in particular those of classification and boundary maintenance. It also involves the development of major new theoretical concepts, with which to make sense of the conduct of practice and the development of formal knowledge. These include the concepts of 'reflexive eclecticism', 'progressive hypothesis development', 'comparative hypothesis assessment', the 'practice paradigm of social work', and the principles of 'convergence' and 'adequacy of fit'. These provide significant bases with which principles may be developed through which a practice relevant knowledge base might be developed. The Theory of Emergent Understanding and Social Science Based Assessment Schedules present significant developments in the problem of relating theory and practice, and these concepts present means for further and more closely relating together the practice of social work and its knowledge base.

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MENTAL HEALTH AND COMPULSORY ADMISSIONS ASSESSMENTS.**

**CRITICAL APPRAISAL.**

Please Note: all references in brackets refer to publications which are the subject of this submission. Otherwise references are numbered.

**INTRODUCTION.**

This submission seeks to establish the case that this corpus of work makes a significant and original contribution to a central problem for social work as a profession: the status in relation to practice of its formal knowledge base. The submission establishes for the first time, that social work possesses a distinctive form of practice consistent with its formal knowledge base. This is evident in terms of the distinctive psychosocial domain of social work, in which interpersonal skills have a major part. In the process this work draws upon a number of concepts from occupational and educational sociology: in particular those of classification and boundary maintenance. It also involves the development of major new theoretical concepts, with which to make sense of the conduct of practice and the development of formal knowledge. These include the concepts of reflexive eclecticism, progressive hypothesis development, comparative hypothesis assessment, the practice paradigm of social work, and the principles of convergence and adequacy of fit. These provide significant bases with which principles may be developed through which a practice relevant knowledge base might be developed. The Theory of Emergent Understanding and Social Science Based Assessment Schedules present significant developments in the problem of relating theory and practice, and these concepts present means for further and more closely relating together the practice of social work and its knowledge base.

**THE ISSUE.**

A significant, perhaps *the* significant, issue for social work as a profession is the status in relation to practice of its formal knowledge or theory base. This involves the fundamental issue of the validity of training. Although interest has been wide ranging, attention has frequently been focused on social science in general, and Sociology in particular. The issue has been subject to intense debate, and as Sibeon and Webb have pointed out, has

prompted an extensive reappraisal of the place of social science and sociology on the curriculum<sup>1</sup>. The basic positions of the protagonists are well established. Opinion may be divided into two, admittedly disparate, groups, one sceptical and the other more positive about the usefulness of theory.

Those sceptical of this formal knowledge have fallen into three broad camps:

1. The status of social science, some believe, is uncertain. It is characterised by theoretical diversity, a lack of consensus, conflicting results and a poor predictive record. Questions exist about whether a cumulative knowledge base can ever be developed<sup>2</sup>. This hardly, it is thought, provides a solid base for its application to practice.
2. Others have suggested that practitioner constraints are more significant<sup>3</sup> than theory, that Sociology in particular has a critical edge undermining practice (although possessing some limited relevance)<sup>4</sup>, and that social workers would do better to focus on knowledge of the welfare state and its resources<sup>5</sup>.
3. A third view is that social work is centrally about understanding others, a primarily intuitive process, and that any formal knowledge has a subordinate status<sup>6</sup>.

Others have been more positive.

1. One view, by Hardiker, is that theory is implicit in practice. Although practitioners are frequently unaware of its use it is nonetheless critical to practice and evident when researched appropriately<sup>7</sup>.
2. Others have suggested that the 'theory gap' is in part a practice-academic culture gap, together with a failure to adopt consistent principles for choosing and developing appropriate knowledge forms<sup>8</sup>.
3. A third view is that social science cannot be 'surgically removed' from social work, concerned as it is with the social world, and that micro sociology is a particularly fruitful source of knowledge. Sibeon has suggested that a non reductionist and reflexive sociology of the middle range is most appropriate for contemporary social work<sup>9</sup>.



One subsequent group of contributors are not concerned about whether social science may be applied, but how this could happen. They recognise this is not unproblematic. They are quite variable, ranging from those who would use middle range theory<sup>10</sup> to others who would use different methods of application according to the type of theory and type of practice used<sup>11</sup> to still others who advocate reflexivity in theory use<sup>12</sup>. Another group are more concerned with the language of the debate than substantive issues. We should, they think, examine the discourse used when considering the importance of theory for practice<sup>13</sup>. They do, however, recognise a central problem in the 'scarcity of theoretical accounting of practice'<sup>14</sup>. A final group, less concerned with the broader issue of the social work-social science relationship, have advocated the use of evaluative studies of social work practice as one of the best ways of developing the occupation's knowledge base<sup>15</sup>. Indeed, some consider the curriculum should emphasise methods whose effectiveness is demonstrated<sup>16</sup>.

In view of the importance of, and controversy surrounding, this issue, it has been subject to remarkably little research. One approach, examining practitioners' accounts of their practice has found little evidence of direct use of theory<sup>17</sup>. Theory is not, according to these studies 'applied' knowingly to practice. In the absence of any direct theory use, researchers have been apt to suggest a 'subconscious assimilation' thesis whereby theory informs practice without practitioners being directly aware of it<sup>18</sup>. A further approach, examined the way students attempted, with greater or lesser success, to make theory relevant for practice<sup>19</sup>. The immediate concern students have with education and training is likely to have made the concentration on their accounts of practice more productive compared with more experienced and qualified practitioners. Another recent student study argues that the theory-practice problem was less about the issue of 'applied knowledge' than how practitioners construct 'good' practice from competing ideologies. However, this approach assumed that social workers *qua* social workers are able to choose the ideology that suits them, which takes no account of the role constraints and consensus assumptions of practice<sup>20</sup>. The work most closely associated with this issue, finally, is Hardiker's, who sought to excavate, particularly from probation reports, practitioners' implicit use of theory<sup>21</sup>. However, this did not involve classification of their formal knowledge (as opposed to its practice use) and without a comparison group she was vulnerable to criticisms that there was nothing distinctive about social work. The 'theory' may be no more than that available to the intelligent layperson<sup>22</sup>.

Two central unresolved issues, therefore, arise from this debate:

- The extent to which social workers can be said *distinctively* to reproduce theory or formal knowledge in their conduct of practice, and
- The twin problems of the unfettered growth of theories or formal knowledge, which, according to Howe<sup>23</sup> involves the steady accumulation of 'unrelated relics' rather than real knowledge development, and the apparent failure, according to the 'subconscious assimilation' thesis, of practitioners to recognise their use of theory in practice .

These studies sought first to discover the extent to which formal knowledge was reproduced in practice by social workers and then to develop principles and methods by which formal knowledge, particularly social science, could be related more overtly, closely and consistently to practice.

#### KNOWLEDGE AND SOCIAL WORK.

This problematic relationship requires first a theoretical understanding of its origins. This was undertaken in this submission through a conceptual analysis of two related issues: the diverse ontological and epistemological issues underlying social science, and the consequent disparate ways of applying social science and evaluating this application.

##### *Social Science*

Three major traditions of social science were identified and compared (Sheppard, 1995, Part 111, Introduction): Positivism, Interpretivism and Realism<sup>24</sup>. Analysis of key elements of these traditions showed that their conception, broadly, of what constitutes knowledge differs in quite fundamental ways, which may be summarised thus:

- For the interpretivists the issue of meaning and understanding are central; for the positivist they are at best peripheral; for the realist, they are the *entrée* to more profound explanations.
- For the positivist an objective reality exists and it is observable and unproblematic; for the interpretivist all perceptions of the 'world' are interpretive, involving active

organisation by the mind; for the realist there is an objective reality, but it is not confined to the observable.

- For the positivist, knowledge is objective and cumulative; for the interpretivist it is largely 'created' and merely an interpretation; for the realist it is provisional and theory soaked.
- For the positivist, scientific interpretations will provide us with a true representation of reality; for the interpretivist, no one form of knowledge is superior to another; for the realist one theory may be better than another if it explains more.
- For the positivist the subject's viewpoint is subjective and secondary to scientific explanation ; for the interpretivist the views of the subjects, in social science, is what we aspire to discover; for the realist they are an important factor to be included in our general explanation of social life.

#### *Applied Knowledge.*

A critical analysis of the notion of 'applied knowledge' was undertaken within the framework of the dominant intellectual traditions in social work. Three traditions were identified: an experiential model, an 'applied social science' model and an interpretivist model (Sheppard, 1995, ch 8). These approaches differ not only in relation to the status of 'knowledge for practice' but also in the way its effect in practice may be evaluated. Experientialism emphasises social work knowledge that is distilled from individual experience. On the job, experientially acquired practice wisdoms are here regarded as being of far greater importance than formal or written (professional) knowledge. There is a strong adherence to a belief in the uniqueness of the individual and a reluctance to entertain generalisations<sup>25</sup>. A directly associated dimension is the existence of an oral culture which exists alongside, and whose insights are considered more profound than, the formal knowledge of written texts<sup>26</sup>.

The approach characterising Applied Social Science is one which involves the development of laws or principles which are then applied to practice. This involves a separation of theory and practice into distinct domains, and in the application of that knowledge, a unidirectional relationship, from theory to practice. It is an approach of instrumental reasoning. In its most firmly positivist form, the evaluation of practice is

undertaken through an experimental design of empirically based outcome investigation<sup>27</sup> Interpretivist approaches, focusing particularly in education and learning techniques have been particularly associated with the 'transfer of learning'<sup>28</sup>. This emphasises meaning in the understanding of human affairs, active construction of views of actions and events on which basis individuals develop 'perspectives'. Social workers use various perspectives gained from the social sciences, but learning, practice and knowledge for practice are actively constructed by students and practitioners. Transfer of learning is facilitated through the development of concepts which may be applied to diverse areas of practice. Learning is cyclical<sup>29</sup> from theory to practice to theory etc. *or* from practice to theory to practice etc. The examination of practice is undertaken not through an experimental design, but an analysis of the range of concepts and theories used by practitioners<sup>30</sup>.

### THE EXAMINATION OF 'KNOWLEDGE IN PRACTICE'.

#### *Empirical Research.*

The question of knowledge for social work is not, therefore, simply a matter of empirical disagreement, but it goes to the very heart of claims about the status and application of social science knowledge. There is, however, a clear empirical dimension which relates to the extent to which formal knowledge is reproduced in the conduct of practice: to what extent does 'practice' reflect 'theory'? Hardiker's work demonstrated that different 'frameworks for understanding' were used by social workers. However, it was unclear as to what extent this reflected the 'formal knowledge' of social work, or whether this simply reflected, in a social work context, the categories and schemas people use in everyday life, which would not be inconsistent with an experiential emphasis. Crucially, there was a lack of a comparison group. Hence a further issue was the extent to which both formal knowledge and practice are *distinctive* to social work?

It was noted earlier (p 6) that Hardiker's<sup>31</sup> attempt to establish that social work practice distinctively reflected its formal knowledge base ultimately foundered because of the absence of a comparison group. Any attempt to transcend these difficulties required an analysis both of (1) formal theory and practice and (2) the use of a comparison group. This was undertaken by focusing on the work of mental health social workers in comparison with CPNs (community psychiatric nurses) (Sheppard, 1991). This had a number of merits. Mental health social work is a major element of social work practice, while providing greater specificity than an analysis of all aspects of social work practice; CPNs have increasingly laid claim to occupational

territory traditionally the domain of social work, implicitly (and explicitly) claiming similar competencies; yet these occupations undergo separate training leading to separate qualifications. The comparison group resolved the problem, in Hardiker's research, highlighting (potentially) distinctive elements of social work theory and practice. The study, therefore, involved:

1. A comparative analysis of theory available to social workers and CPNs
2. A comparative analysis of practice in the light of this theory.
3. An examination of clients' experience of practice, focusing particularly on skills manifested.

The reproduction of knowledge in practice was considered important for the extent to which this practice 'fitted' with professional role expectations. The analysis was undertaken in the light of role expectations of mental health social workers. The common base for practice - a community mental health centre (CMHC) - involved a high level of interprofessional collaboration, providing a severe test of the extent to which social work practice distinctively reflected theory. In these circumstances we might expect, if experience were more significant than formal knowledge, that the common experience of working together would be likely to lead to a 'convergence' between occupations in the conduct of practice.

### *Methodology*

The methodology emphasised the importance of meaning in the definition and transmission of occupational knowledge (Sheppard, 1991, Appendix; Sheppard, 1995, ch 14; see also Sheppard, 1995, ch 8). Hence, first, the examination of theory, or formal knowledge, and practice needed to be undertaken in terms meaningful to those involved including their definitions of the way they conducted practice. Second, the study was characterised by two forms of triangulation, an approach emphasising that the combination of methods is superior to single methods. These were method triangulation, involving the combination of more than one technique, and data triangulation, involving the use of more than one source<sup>32</sup>.

The procedure involved the analysis and classification of each occupation's theory base, derived from a comprehensive examination of each occupation's theoretical literature. This (a) identified the nature and 'boundaries' of the theory bases (b) provided an analytic framework from which the examination of practice could be undertaken in terms meaningful to those

involved in the study and also to these professions generally and (c) provided a basis of shared meanings by which inter professional comparison could be undertaken. This was undertaken both in relation to their general theoretical foundation and relationship/interpersonal skills in particular.

The analysis of practice was undertaken through a survey of 353 cases referred to the CMHC using structured self administered instruments and a quantitative approach. Survey techniques have been used widely in other studies<sup>33</sup>. With appropriate methodology, Marsh<sup>34</sup> has observed surveys may incorporate actors' meaning into the analysis, while handling data from a high number of cases. The study of theory provided an analytical framework for constructing the instrument's main dimensions. Detailed construction of the questionnaire was a joint enterprise between myself and the social workers and CPNs involved in the study. This meant that data collected would be meaningful for the occupations (and subjects) involved. The self administered nature of the questionnaire meant, furthermore, that data collected reflected practitioners' judgement of what occurred. This approach, furthermore, resolved the problem identified by Paly and Hardiker (discussed above), that practitioners do not tend to refer to theory in their accounts of practice. The close relationship between the definition and classification of knowledge and the methods for examining practice allowed the examination of the extent of knowledge reproduction in practice without relying on practitioners' accounts.

This broad *strategy for the conduct of practice* represented one way of identifying theory-practice links. These links could be further examined in terms of the largely *interview based interaction* between worker and client, which focused on the use of interpersonal, or relationship, skills. These were examined through interviews with clients, since the main justification for their use is that skills help clients or facilitate work with them. It is to clients, therefore, whom we should look for skills assessments. Interviews were undertaken with a stratified sample of 77 clients. However, a central problem was that they would be unlikely to know the language of interpersonal skills - they lacked access to 'meanings' internal to the professions. Two solutions were used. First, client verbal accounts were subject to content analysis<sup>35</sup>, based on the classification of skills identified in theory. Their lay language may have differed, but its content, appropriately classified, might well indicate their experience of skills. Through content analysis, therefore, it was possible to 'translate' clients' experiences into responses about skills. Second, a quantitative analysis was undertaken. This involved the use of a questionnaire which had a classification identical to that used by the professionals. This was completed with the client during the interview. It was designed to focus on communication and case management skills. The questionnaires, developed for practitioners, however, left a

problem of meaning. Differences in practitioner-client responses might arise from different interpretations of the same terms used in the questionnaire, or simply through a lack of understanding of them. They were piloted initially with ten clients, and definitions of different areas were provided, leaving the client to decide whether it was appropriate in their case. Clients found little difficulty with it, except in some technical areas of mental health, which given the study focus were inappropriate to exclude. Interpretation of these data was therefore, treated with extreme care and discussed extensively in the text.

### *The Study.*

#### *(1) The Areas of Discourse in Theory.*

The examination of theory in the study classified seven broad areas of discourse: knowledge orientation, practice orientation, defining the client, context of intervention, contexts specific to mental health, direction and duration of work with clients (Sheppard, 1991, Ch. 2). There was some overlap. The uncertainty of social work's social science foundations is reflected in CPNs' mental health models. Both borrow knowledge from other disciplines, although unlike CPNs social workers have also generated their own knowledge. Both also claim an interest in the psychosocial (although CPNs are also interested in 'bio'). Both professions, furthermore, recognise limits to formal knowledge and ascribe importance to judgement. However, there were noticeable differences also. Phenomena are defined by CPNs primarily through mental health models, while social work emphasises its social science knowledge base. CPNs are more individualistic and social work more developed in relation to their theoretical treatment of social environment. Finally, CPNs raise problems, such as the disadvantage-illness relationship with which their theory does not equip them to deal.

#### *(11) Practice.*

The issue, then was: how far were these trends reproduced in practice? Practice was, first, examined in relation to a survey of 210 brief and 143 extended intervention cases. This division reflected practice at the CMHC. Analysis of brief intervention showed differences in theory were largely *not* reflected in practice (Sheppard, 1991, Ch. 4). The main impression was of similarity between the groups. This was the case with mental health, social and primary problems identified, in roles and activities undertaken and the attribution of cause of client problems. Differences, in emphasis on social environment and practical problems, were the exception and not consistent with expectations from theory. The evidence suggested an explanation emphasising either (1) an uncertain knowledge base with unclear boundaries and

emphasis on practice based judgement, or (2) a 'seepage' of knowledge based on extended contact and collaboration between professions.

However, differences were marked with extended intervention (Sheppard, 1991, Ch. 5). Social workers defined their clients' primary problems more frequently as social (social problem cases) and CPNs' as mental health (mental health cases). Social workers worked more in a wider community context, particularly in relation to resource mobilising or advocate activities and working with outside agencies and professionals (excluding health). They tackled practical and emotional and relationship problems far more than CPNs, whose approach was far more individualistic. Social workers appeared to have a more definable 'philosophy of practice'. They undertook more long term work, this work was of greater intensity and there was a strong emphasis on psychodynamic and emotional support work. This evidence showed practice differences to a considerable degree consistent with theory. It also indicated greater boundaries between occupations than suggested by brief work.

*(111) Skills.*

The examination of theory on interpersonal/relationship skills also yielded notable differences (Sheppard, 1991, Ch. 6). In social work relationship skills, providing the 'glue' binding together disparate areas of practice, are considered fundamental. However, an ambivalence exists in nursing between interpersonal and patient (ie medical) orientations. Compared with social work, nursing examines skills in a fragmentary way, sometimes relatively simplistically. There is an expectation of a greater degree of mastery of these skills in social work and their being learned rather than simply innate. There is also a more consistent attempt to operationalise them in a detailed way.

An empirical examination of skills was undertaken and also divided up into brief and extended intervention (Sheppard, 1991, chs 7-9). A number of observations were made about the use of these data. It was recognised that issues such as, for example, cultural background and experiences and a lack of knowledge of alternatives with which to compare their experience of intervention, may affect client responses (Sheppard, 1991, Sheppard, 1992). With both brief and extended intervention, social work clients identified more skills, made fewer criticisms about misused or unused skills and less frequently suggested that intervention made no difference than CPN clients (or joint clients with brief intervention). Skills were loosely divided into two groups. These were relationship skills, focusing on the human qualities of the practitioners and expert skills, broadly more 'technical'. The examination of brief intervention



revealed an emphasis on relationship skills. Expert skills were more frequently identified with extended work. With brief intervention, social work clients more frequently identified listening, empathic, acceptance and advice skills. With extended work, they identified, in addition to these skills, analytic processes, releasing feelings and increasing self-understanding. The results of quantitative analysis were complex, and did not point in one direction only. However, broadly, social work clients more frequently agreed with practitioners in their definition of problems. Clients of social workers were more frequently aware of activities undertaken, more actively involved in defining, planning and carrying out work and less frequently criticised practitioners for deficiencies in psychodynamic work.

More broadly, a number of observations about skills were made. First, unsurprisingly, clients made comments in the light of experiences outside the practitioner's intervention. Their responses should be considered in this light: a positive view may reflect the awfulness of clients' experiences elsewhere. Second, the key skills with brief intervention were listening, empathy and advice. This suggested even with brief contact, clients wished for an active helpful response based on a 'real' understanding of them. With extended intervention, expert skills of information/advice, analytic processes, releasing feelings and increasing self understanding were more important.

#### *The Reproduction of Knowledge.*

Clearly, there were notable differences between the practice of social workers and CPNs which, to a remarkable degree, reflect differences in their 'knowledge base'. The issue, then was, how could we make sense of this. Conceptually, this was analysed in terms of work drawn from the literature on the reproduction of knowledge (Sheppard, 1995, ch 14). This has three elements: sources of unity, sources of diversity and the orientation towards practical or life experience rather than formal knowledge.

A key element was the importance of meaning in linking of formal knowledge to the conduct of practice. Following Weber<sup>36</sup> a crucial aspect of making sense of social action is meaning: the way subjects understand situations is a central component of their actions. In occupations, shared meaning, often reflecting the assumptive rather than explicit world, are manifested in occupational culture. In occupations with significant education and training components, the possession and transmission of knowledge is a key component of shared meaning. These shared meanings may be presented in terms of common ways a group possesses of categorising and interpreting the world, through

common schemas<sup>37</sup>. However, as Atkinson observes<sup>38</sup> accepted knowledge is not simple, objective and uncontroversial, but is classified and combined in certain ways. It is a cultural imposition. The work drew further on Becher and Bernstein<sup>39</sup>, who used the concepts of classification and boundary maintenance to examine the separation of areas of knowledge. It is in this respect, that the curriculum can influence the extent to which members of a profession can have a common way of understanding situations confronted in their professional life. The curriculum represents the means by which we can define, classify and structure the reality confronted in professional life. In Bernstein's<sup>40</sup> terms Classification refers to the organisation of knowledge into curricula, or the various domains of educational activity. Becher<sup>41</sup> identifies the saturation 'of epistemological discussions with spatial metaphors: fields and frontiers...charts and landmarks' in the discussion of educational domains. Boundary, for Bernstein, refers to the external limits to one discipline, which differentiates it from others. Strong boundary maintenance can lead to completely different perspectives according to different occupational knowledge orientations. Boundary may not, Becher thinks, relate simply to the 'edges' of subject matter, but also to distinctive approaches to the same subject matter. These are of three types: a distinction of style or emphasis, a division of labour, or difference in conceptual framework.

A conceptual analysis of sources of diversity as well as homogeneity was also undertaken. This is of significance when attempting the empirical analysis of the reproduction of knowledge through particular case examples. Bucher and Strauss<sup>42</sup> drew attention to the possibility of 'segmentation' within occupational groups on the basis of specific and divergent interests. Gouldner<sup>43</sup> distinguished between 'locals', whose group loyalty is focused on the organisation and 'cosmopolitans' whose wider reference is the professional group. Ruscio<sup>44</sup> suggests that 'either-or' formulations (heterogeneous-diverse versus homogeneous-unified) are not helpful. He writes of unifying and segmenting tendencies. Drawing on a biological analogy, he distinguishes the 'genotype' from the 'phenotype'. The former represents the fundamental instruction to the organism while the latter represents the actual manifestation in a particular physical setting. Hence there may be both unity and diversity within a particular occupation. Becher<sup>45</sup> similarly distinguishes convergent from divergent disciplines. The former are tightly knit with strong common values and perspectives while the latter are loosely knit disciplines without a clear sense of cohesion or identity.

The applied nature of social work raises further issues around the importance of applied knowledge relative to life or practice experience. There may be a difficulty of 'fit' between theory and practice and formal knowledge in some areas may be absent. Practitioners may be reliant on their 'lay' formulations, while their 'virtualities' - the flair they show in the use of their knowledge - may be significant<sup>46</sup>. Attitudes, as Friedson has observed, may also be significant: the extent to which experience rather than formal knowledge is valued. In medicine this has been called the 'clinical gaze' or training for dogmatism<sup>47</sup>.

The analysis of practice indicated that, perhaps surprisingly, the 'knowledge boundaries' were relatively strong between social workers and CPNs. This, furthermore, suggested that 'knowledge seepage' between CPNs and social workers was relatively limited. Prolonged and close contact had not led to two occupations characterised more by their similarities than their differences, rather the reverse. Hence, it would appear that unifying rather than segmenting aspects are most apparent in this comparative analysis. Indeed, if experience were more significant than formal knowledge, we might have expected that the common experience of working together would have rendered more similar the approaches of the social workers and CPNs. Yet social workers retained a distinctive practice reflecting the distinctiveness of their formal knowledge.

#### *Focus.*

While concepts such as classification and boundary maintenance provide conceptual links between formal knowledge and distinctive characteristics of social work practice, our understanding is incomplete until we relate this to the kind of activity social work is. Applied knowledge does not exist in some kind of 'intellectual limbo', but has a focus. This involved two interrelated areas of significance. First, what is it that this knowledge is being applied to? what is the knowledge for? Second, how is the definition of the phenomena with which social workers deal related to the forms of knowledge used? This was presented earlier in terms of roles, but this was more formally or conceptually considered in terms of social work as a socially constructed activity (Sheppard, 1995, Ch 3).

These issues helped contextualise the use of knowledge. Social work as an activity may be understood in two key ways. Social workers *qua* social workers deal with people who have been socially defined in some sense as socially problematic - hence their concern,

for example, with child abuse and mental illness<sup>48</sup>. These definitions may be contested, but their institutional acceptance implies, within the 'assumptive world' of social work, a high degree of consensus. Social work's *concern* with socially defined individuals is carried out under the aegis of state delegated authority<sup>49</sup>. This is manifested largely through agency function, but may be more directly delegated to social workers, as with compulsory admission assessments (Sheppard, 1990, part 1; Sheppard, 1995, ch 3). Hence, if knowledge is to be applied to practice, its focus is on people who have been socially defined in particular kinds of ways. Social work was further formulated in terms of an *orientation* towards the socially defined individuals as subjects and an interactional *focus* for practice. (Sheppard, 1995 ch 3) These formulations of concern, orientation and focus make meaningful an emphasis on interpersonal skills and a psychosocial approach to intervention.

## DEVELOPMENT OF SOCIAL WORK KNOWLEDGE.

### *The 'Practice Paradigm' of Social Work.*

These observations provide clues to the forms further development of formal knowledge for social work might take, which were explored in the work which is the subject of this thesis. If knowledge is to develop in a way relevant for social work, it was argued, it must take account both of the nature of social science knowledge and the focus for this knowledge (social work). This work sought, furthermore, to build on the observations about knowledge and practice domains by examining two further issues: how can social workers utilise a process of reasoning which minimises the likelihood of error? and how can we develop a framework which will allow for the incorporation of both formal and experiential knowledge? This, then, focused on the principles and methods by which formal knowledge may be related more overtly, consciously and consistently to practice, while recognising its limits. A key to this was the 'excavation' of the 'assumptive world' of social work, one which provided the basis for 'practice consistent' knowledge forms. In this a realist approach was taken, one which characterises the assumptive world of social work. Knowledge for social work was considerably aided by the systemisation of this assumptive world, which was formulated in terms of 'practice led theory'. This was contrasted with 'theory driven' practice, characterised by a conception of social work unrestrained by practical constraints, as, for example with Marxist approaches<sup>50</sup>. 'Practice led theory' had three elements: the practice paradigm of social work; the

principle of convergence; and the principle of adequacy of fit. This was developed in Sheppard (1995) chapter 10 (see also chapters 6 and 7).

The 'practice paradigm' of social work is assumed in practice, rather than generally overtly stated (Sheppard, 1995, ch 10.). Drawing on earlier chapters extensively analysing the senses in which need, empowerment and self determination are used in social work (Sheppard, 1995, chapters 6 and 7) three key dimensions were identified: an objectivist core to the definition of phenomena with which social workers deal (eg that child abuse or mental illness really and objectively exist); an approach to explanation of these phenomena in terms of a 'limited voluntarism'; and an appropriate focus for practice governed by structural constraints and which is consistent with what is described in academic terms by Burrell and Morgan<sup>51</sup> as the 'sociology of regulation'. Useful knowledge for social work, therefore, will be that which is most consistent with the 'practice paradigm' of social work. A second element was the principle of convergence, which involved distinctions between between (a) foreground and background knowledge and the concepts of (b) theoretical specificity and (c) research validity. These were explored in some detail in Sheppard (1995, ch 10). The final concept developed was that of 'adequacy of fit', to characterise in specific practice situations, the criterion for choosing between relevant forms of knowledge.

The notions of practice led theory provided the context for the further development of relevant forms of knowledge. The first involved the notion of the social worker as 'practical qualitative researcher' and the second involved the development of social science based assessment schedules. Both, and particularly the first, involved the concept of *reflexive eclecticism* which characterises the Theory of Emergent Understanding. These original concepts were developed through extensive theoretical analysis which will now be summarised.

*Social Workers as 'Practical Qualitative Researchers' : Towards the Theory of Emergent Understanding.*

The theory of emergent understanding is designed to reflect the nature and limits to human understanding. This was developed in Sheppard (1995, ch 9; Sheppard, 1995a). It characterises practice understanding and intervention as a continually emergent and dynamic matter. It is case based and seeks to bring together formal and experiential knowledge in a way which allows for the most adequate fit between the situation and the

social worker's understanding of it. It draws, first on the centrality of the concepts of meaning, social action and social interaction (Sheppard, 1995, ch 9). *Verstehen* is interpretive understanding<sup>52</sup> and was considered to contain three key elements: intuition<sup>53</sup>, the capacity to impute motives<sup>54</sup> and the capacity to understand and follow rules<sup>55</sup>. Together these constitute the internal 'psychological' and external socially contextualised elements of meaning. *Social action*, after Weber<sup>56</sup>, was considered to occur when a social actor ascribes certain meaning to their conduct and by this meaning is related to the conduct of others. *Social interaction* occurs where actions are reciprocally oriented towards the actions of others. *Reflexivity* is a concept of further significance because actions are not unproblematic and may be ambiguous. Reflexivity describes the process by which we ascribe meaning in social interaction<sup>57</sup>, including reflection on ourselves and others, monitoring acts of ourselves and others and creating ways of explaining situations.

This process was formalised by drawing on concepts of categories and schemas - the concepts and 'naive theories' which we use to make sense in everyday life. Categories and schemas (from everyday life) and concepts and theories (from formal knowledge) provide the means by which we can 'make sense' in practice situations. They may be applied in a search for the 'most adequate fit' with the situation confronted. This is achieved using a further process characteristic of methods of human understanding: the creation and testing of hypotheses<sup>58</sup>. The hypothesis testing process is one which seeks to disconfirm our understanding of particular situations. This is critical because of evidence that humans possess a 'confirmation bias' through which they seek to confirm existing hypotheses and which may lead to mistakes in practice. This is arguably highlighted by some child deaths when the children were under the supervision of social workers<sup>59</sup>. Reflexive eclecticism, therefore, entails:

1. The generation and incorporation of a wide range of schemas of potential relevance to practice situations.
2. The use of a retroductive approach to the process of analysis, involving high levels of sensitivity to disconfirming evidence.
3. A case based focus for knowledge for practice in which the 'adequacy of fit' of schema or theory is the test of appropriateness.

It combines, therefore, the processes of making sense and reasoning. This argument was taken further in relation specifically to the qualitative nature of social work practice (Sheppard 1995a). This article argued that both interpretivist and positivist approaches to social science tended, for different reasons to give the social scientist a privileged position, creating an unwarranted gap between social science and everyday life understanding. Indeed the method of experimentation is not simply a matter for the lab scientist, but is part of the methodology of everyday life<sup>60</sup>. Hence everyday life even has the appropriate language. Good experimental methodology is called, in everyday life, 'trial and error' - a process of hypothesis testing until the right conclusion is reached. Poor methodology is termed 'jumping to conclusions', where an individual derives an incorrect meaning from a situation by inadequately considering alternative positions. If we look at the process of making sense, rather than the product of social science, there is rather less of a gap between social work practice and social science than many have argued.

What distinguishes social science is its greater rigour<sup>61</sup>. Practice may learn then from this rigour, and Analytic Induction, a qualitative research methodology, was used as an heuristic device to explore the potential for greater practice rigour. From this, two concepts of hypothesis testing were developed:

- *Progressive hypothesis development*: a step by step approach of examining hypotheses one by one, abandoning those which confront disconfirming evidence until the one most adequately fitting the data is developed.
- *Comparative hypothesis assessment*, where a number of competing hypotheses may be used to identify their 'fit' with the data.

Hypothesis generation and use is efficacious because it involves a commitment to precision and explicitness and because it provides the focus for both social science knowledge and experiential knowledge. Furthermore, hypotheses contribute to the development of practice wisdom in two ways: where they have been found relevant for similar problems (problem relevant hypotheses) and where they are generic or transferable (eg loss as relevant to unemployment and bereavement). The practice community possessing a rigorous concern for evidence and a routine scepticism was characterised as possessing *critical awareness*, a concept based on the general application of reflexive eclecticism.

The systemisation of our understanding of practice is therefore characterised as a rigorous and reflexive exercise, which reflects the limits to human understanding, the characteristic ways in which humans 'make sense' and draws upon formal and experiential knowledge in a case based fashion. Its Realist orientation, reflected in the concept of limited understanding and 'adequacy of fit' differentiates it from both Applied Social Science and Interpretivist formulations. Its emphasis on emergence distinguishes it from the Applied Social Science model, and its systemisation of hypothesis testing, the search for disconfirming evidence and emphasis on 'adequacy of fit' distinguishes it from interpretivist models of the relationship between knowledge and practice.

*Developing Social Science based Assessment schedules.*

Social Science based assessment schedules are instruments which may be used directly in practice by social workers and which are based on social research. Their development incorporates the principles of 'practice led' theory, outlined earlier. The method for their development was conducted through an exemplar: research on Approved Social Work (ASW) practice, which led to the development of the compulsory admissions assessment schedule (CASH). This reflected clearly the key elements of 'practice led theory' identified earlier. This was manifested, not simply in terms of the practice paradigm of social work, the principle of convergence and that of adequacy of fit. It also involved (a) that the assessment schedule was structured in a way that reflected the key domains and categories of knowledge identified in the research and (b) that its conceptual schema reflected the theoretical understanding developed in the original conceptualisation and analysis of practice. It also involved an approach which allowed for the evaluation of the assessment schedule, to discover whether or not it was usable and made any difference in practice. These factors exemplified, in the context of a semi structured schedule for practice, all the key elements of practice led theory.

The focus for this study was a particularly significant area of practice, assessment for compulsory admissions (sections) by approved social workers (ASWs) under the Mental Health Act, 1983 (the Act). Under the Act an individual may be sectioned if, in brief, in the belief of the assessing individuals, he or she is suffering from a mental disorder and admission is in the interests of his/her own health or safety or the protection of other persons (the 'health or safety' criteria). This is a little researched area, and only Barnes *et*



at<sup>62</sup> have made a significant contribution. Their work focused on quantitative social and demographic correlates of compulsory admission.

The central focus of this study was the interpretation, in practice of the 'health or safety criteria'. This involved a theoretical analysis of the role of the ASW, and an examination, in the light of this theory, of the interpretation by ASWs of the 'health or safety criteria' when undertaking section assessments. In the light of limitations identified in this area by the research, a new knowledge base was developed, the Compulsory Admissions Assessment Schedule (CASH). It was intended that the health or safety criteria would be more systematically and consistently applied by social workers using CASH. This hope was borne out by the subsequent analysis of its use by ASWs. In broader terms, this involved developing an approach where social science might be more directly related to practice through social science based assessment schedules.

### *Theoretical Approach.*

While the central place of knowledge as an (occupational) cultural imposition was retained, ASWs' actions were further examined within their state defined role. This definition, consistent with the notion of social work as a socially constructed activity (see Sheppard, 1995, ch 3) has implications for the meanings attached by ASWs to their acts (Sheppard, 1990, Part 1). ASWs were presented as concerned with mental health as a social problem rather than a health problem *per se*, with an understanding of social problems drawing on Merton and Nisbett<sup>63</sup>. ASWs' particular interest is with deviancy rather than disorganisation. This deviancy is identified against (implicit or explicit) norms, established either (through statute) by the state or (in practice) by ASWs (amongst others). Second, their authority is delegated by the state. This process, according to Wilding<sup>64</sup>, implicitly involves defining the problem as personal, susceptible to individual solutions by experts. Third, ASWs act in two ways as 'rule enforcers'. This drew on Hart's<sup>65</sup> concept of the 'open texture of law'. ASWs were considered to operate within this 'open texture'. This 'open texture' involves circumstances where legal rules operate at a level of generality preventing their precise application to individual situations. They therefore require interpretation (the function of precedent in courts) in this case made by assessing professionals. This open texture in principle gives ASWs a wide degree of discretion. ASWs are rule enforcers in another way: with residual rule breaking. Scheff<sup>66</sup> consider these are rules of behaviour demarking the normal from the odd or strange, and psychiatric symptoms may be presented (sociologically) as residual rule breaking.

Finally, ASWs have a 'right to define' what an individual needs rather than what that individual wants<sup>67</sup>. This reflects what Parsons has called the 'primacy of cognitive rationality'<sup>68</sup> and gives ASWs their capacity to ascribe (with others) an official identity as well as provide access to resources.

Further factors emphasising the normative aspect and assumptions were of theoretical significance for ASWs exercise of discretion. These were occupational culture, particularly knowledge orientation<sup>69</sup>; illness as a social state involving expectations about help seeking behaviour and behaviour when actually ill<sup>70</sup>; and the commitment to legalism, involving the accurate use of the law and its processes in the conduct of practice.

### *Methodology.*

The study adopted an action research approach. This is distinguished by its concern both with practical concerns of people in problematic situations (ASWs in relation to section assessments) and the goals of social science (understanding practice and developing the knowledge base)<sup>71</sup>. A second characteristic is its developmental nature. Research is used to make observations about practice from which improvements may be identified, put into practice and evaluated by comparison with the original position. Zuber-Sheritt<sup>72</sup> identifies four phases: planning, action, observation, reflection. These four phases were evident in this study. They were the problem specification and development of theoretical framework; the analysis through this framework, of practice; the development of CASH through reflection on practice; the examination and evaluation of its use; and reflections on the process of knowledge development and implications of its use. Action research then (a) provides a means for bridging the theory-practice 'gap' identified by Sheldon<sup>73</sup>, and (b) emphasises subjects' understanding of their actions through a stress on collaboration between researcher and practitioner.

### *Stage One.*

#### *(1) Methods:*

Stage one of research was concerned with the interpretation by ASWs of the 'health or safety criteria' in practice situations. It adopted a qualitative methodology and focused on two central issues: the process by which ASWs carried out assessments, and more

specifically, their assessment of risk in relation to the 'health or safety criteria' (Sheppard, 1990, Part 1). These methods are particularly useful where we cannot know in advance the main ways of classifying and making sense of information<sup>74</sup>. They also allow subjects to describe their actions in their own terms, allowing the researcher to incorporate meaning into the analysis of responses<sup>75</sup>. The semi structured, rather than conversational technique of unstructured interviews, was consistent with the conceptualisation of ASWs as state functionaries. Since the concern was the way they carried out their duties prescribed by the Act, it was possible to identify in advance the main issues. ASW responses were examined within the conceptual framework of Risk Analysis, which, drawing on Brearley<sup>76</sup>, is divided into hazards, dangers and risks.

*(11) Results:*

120 referrals to ASWs at a CMHC were examined in this way. These constituted nearly all daytime referrals in a city of 250,000 over a one year period. The qualitative analysis of risk assessment indicated that, in a significant minority of cases, a lack of clarity clouded ASW assessments of their cases, making it difficult to justify adequately their actions (Sheppard, 1990, Part 2). This was associated with what I called a 'presumption of risk': a view of situations involving mental illness as inherently risky. Second, the classification of the application of the 'health or safety criteria' revealed a wide range of factors used in interpretation of these criteria. These ranged from death on one hand, to family integrity or reputation of a public figure on the other. Evidence was overwhelmingly based on information and observation, although knowledge based on psychiatric condition and previous acquaintance with the patient were also used. Fourth, on some occasions mental health was used as the health or safety criteria, consistent with official advice<sup>77</sup>. Hence some individuals (but not others) were sectioned on mental health grounds alone. Finally the development of the classification revealed some inconsistency between ASWs in their application of the 'health or safety criteria'. This indicated a wide 'threshold of risk' distinguishing those sectioned from those not sectioned.

Many of these factors were identified with what I called a 'Mental Health Orientation' - a tendency to give priority to mental health state over health or safety criteria in making decisions. This orientation is consistent with GP and wider medical referrals<sup>78</sup>. This originated, I suggested in (a) the lack of formal knowledge base to assess risk (b) the extensive psychiatric knowledge base and (c) the wide discretion given ASWs. An

alternative 'Social Risk' orientation was developed, giving equal status to the 'health or safety criteria', which, I argued, was a natural 'home' for ASWs. Given the imbalance of knowledge with the powerful psychiatry knowledge base, and the complexity of assessments, the need for an ASW knowledge base, within this Social Risk orientation was apparent.

### *Stage Two.*

#### *(1) Development of the Compulsory Admission Assessment Schedule.*

This knowledge base was encapsulated within CASH. This was an assessment schedule developed for the direct application of theory to practice (Sheppard, 1990, Part 3). It is a semi structured instrument designed for use in practice, and was developed with extensive instructions (and definitions) in relation to three key areas: the main dimensions of the relevant sections of the Act, the conceptual framework of Risk Analysis, and the range of factors considered to be significant in research. These latter factors were further developed with ASWs in the light of their practice and its use.

Hence CASH was developed along the following dimensions.

- *Hazards*: classified in the light of research and subsequent discussions with ASWs.
- *Dangers*: were divided, as with the Act into health threat (mental and physical), safety threat and threat to others. This was further conceptualised in terms of (a) the nature and severity of the danger and (b) the significance of vulnerabilities (related to the danger).

An overall rating of seriousness of danger was made by the ASW in the light of this assessment.

- *Risk* was assessed by reference to two sets of factors. Factors relating to the behaviour of the person comprised the first set and these may reduce or increase the risk of the danger occurring. Social support comprised the second. This focused on whether it (social support) existed and its capacity to reduce the likelihood of the danger occurring.
- *Evidence* was examined in terms of comprehensiveness and reliability.

A rating of level of risk was then made on the basis of the analysis of risk and evidence provided. Together with seriousness of danger this gave a rating of Overall Risk. It should be noted that while CASH sought to develop formal knowledge for practice and encourage systematic and conceptually clear assessments, the judgement of Overall Risk was left to the ASWs themselves.

Alongside the development of CASH were a series of meetings with ASWs in the study, serving two purposes: to acquaint ASWs with, and gain their help in refining, CASH; and to train them for its use in preparation for its evaluation. This involved extensive discussions at group or individual level as well as a 'pilot' period of three months when CASH was used in actual section assessments. During this time CASH was under constant review, and the ASWs became proficient in its use.

*(11) Evaluation of the Compulsory Admissions Assessment Schedule.*

CASH was evaluated on the basis of expectations about the impact of its use noted in its development (Sheppard, 1993). The first of three methods used was a quantitative approach, based on data derived from the use of CASH in practice. The second, qualitative approach involved the use of methods similar to stage one. Silverman<sup>79</sup> advocates a simple numerical approach to qualitative research. This provided an indication of the relative significance of different responses and allowed the frequency with which clarity was displayed in stage one assessments to be compared with stage 2. Qualitative methods also contributed to the analysis of consistency between ASWs in their assessments. This was undertaken, first, by comparing the Overall Risk ratings with which different ASWs distinguished those who could be sectioned from those who could not. However, the apparent consistency of quantitative data might reflect suppression of real differences of criteria used to rate cases. This was examined through classifying and relating qualitative reports of patients' circumstances to ASWs ratings of cases. Third, ASWs were asked to assess the usefulness of CASH in terms of the extent to which it helped (or not) their assessment and the time it took to complete. This reflected the need to identify whether CASH was considered to benefit those for whom it was intended.

CASH was evaluated through its use by five ASWs, in relation to a further 71 referrals over one year. In view of training requirements and rate of referral this represents a substantial sample. It was shown to be highly sensitive to differences between those who could and those who could not be sectioned and ratings of severity were consistent with

the nature of danger identified. The use of CASH was associated with a narrower rather than wider interpretation of the law, emphasising particular dangers of death, injury and serious illness. The qualitative analysis of ASW accounts showed the use of CASH was associated with a higher degree of conceptual clarity than was evident in the stage one research. It was practical to use, generally seen positively by ASWs and considered particularly helpful in cases where decisions were difficult to make. The success with which it could be used suggested it could provide the basis for wider accountability for actions that are otherwise carried out away from public gaze, yet nonetheless are significant for personal liberty. Analysis of qualitative data showed a higher degree of consistency than evident in stage one research. An additional benefit, not anticipated, was the development of a classification of case characteristics associated with different ratings of seriousness of danger and which may potentially be used on a wide basis to encourage consistency in the conduct of assessments.

#### THE CONTRIBUTION TO KNOWLEDGE OF THESE STUDIES.

This corpus of work focused on the the theory-practice problematic of social work and sought to understand and develop the relationship between social work practice and its formal knowledge base. The work was, overall, characterised by an emphasis on the importance of meaning, both in understanding and developing the relationship between theory and practice. This was undertaken first by an examination of the different traditions which underlie perceptions of the theory-practice relationship. It then sought to examine the distinctive ways in which knowledge was reflected in practice through a comparative analysis of the work of social workers and CPNs in the light of their formal knowledge base. This was understood in terms of occupational meaning expressed through the reproduction of knowledge in practice, emphasising in particular the concepts of classification and boundary maintenance. The further understanding and development of knowledge for social work was based on the two key elements of the nature of social work itself and its social science knowledge base. Within this broad framework, the key elements of social work's practice paradigm, and the principles of convergence and adequacy of fit were constructed as a basis for further developments in knowledge for practice. Two themes were developed from this: the Theory of Emergent Understanding and the use of Social Science based Assessments Schedules. The work leading to the construction and use of the compulsory admissions assessment schedule represents an exemplar of the way in which social science based assessment schedules may be developed. At the heart of the problem of understanding and developing the relationship

between social work and its formal knowledge base lies the issue of meaning, and although there are a number of complex conceptual and empirical issues which relate to this, meaning must remain a central feature of our concern with 'theory and practice'.

Overall, the work was carried out within a framework which sought to understand the nature and development of social work knowledge in terms of two key elements: the nature and status of social science knowledge and the nature of social work itself. Hence the intellectual framework from which the work developed started, on the one hand, with an examination of the intellectual traditions of social science and a critical analysis of the notion of applied knowledge in the light of these traditions (Sheppard, 1995, Part 3). On the other hand the framework was developed through a critical analysis of views about the nature and purpose of social work itself, involving both normative and positive theorising, and including concepts such as social functioning, self realisation and empowerment as well as that of state functionary (Sheppard, 1995, chs 2 and 3). This clearly indicates that we cannot consider the nature and use of social work knowledge without considering what it is being applied to. Knowledge for what? is a key factor here.

This dual approach of *detailed theoretical analysis* to contextualise the examination of social work knowledge is novel. Most authors<sup>80</sup>, have tended to consider the issue of knowledge without this extensive analysis of the nature and purpose of social work, which has tended to remain implicit or insufficiently examined. This dual approach, furthermore, created the framework through which we could use further concepts to make sense of knowledge for practice. This was the case, for example, with concepts of classification and boundary maintenance for the analysis of existing practice, and quite crucial to the development of further concepts such as the elements of practice led theory, including the practice paradigm of social work and the principle of convergence. These latter concepts could not have been developed without this dual approach.

The examination of mental health social work in the light of community psychiatric nursing was the first attempt to bring together theory and practice in a coherent analytic framework which sought to examine practice in the light of, and only after, a comprehensive analysis and classification of the realm of theory discourse conducted in social work (and community psychiatric nursing). In so doing it was the first study to draw upon an analytic framework emphasising accepted professional knowledge as a cultural imposition, creating a 'knowledge space' associated with the occupation which may then be reproduced in practice.

Its comparative approach was (in this context) also novel. A central problem of previous research, particularly that of Hardiker, was the lack of a comparison group facilitating the identification of theory and practice which is distinctive to social work. While Hardiker teased out the 'implicit theory' used by social work practitioners, without a comparison group, we cannot know whether this was no more than the representation, in social work, of the process of making sense in everyday life. The empirical result, then, was that the work identified that which is distinctive to social work.

The work was novel, in further, theoretical, respects. The key concept of Reflexive Eclecticism in the Theory of Emergent Understanding was systematically developed and novel. The concept of reflexivity has rarely been mentioned<sup>81</sup> and never systematically developed in relation to social work practice. By identifying the characteristic ways in which humans 'make sense' of their social world, a framework was created which allowed both formal and experiential knowledge to be incorporated. Previous writers, using an interpretivist approach had emphasised the development of 'frameworks of meaning' which social workers could use to understand practice situations. Other writers in the applied social science tradition (notably Sheldon) have emphasised an hypothesis testing falsification approach. In creating a framework for combining the two, and linking this to the human capacity for reflexivity, the concept of reflexive eclecticism was able to create depth as well as breadth of understanding in relation to any particular practice situation.

However, it emphasised not simply frameworks for meaning, but also the process of reasoning. Using a Realist (epistemological) approach and a retroductive methodology, these approaches allow for the practitioner to identify and develop the category, schema, theory or concept, least likely to be wrong in any practice situation. This is the probabilistic equivalent of falsificationism. It also provides for the process of reasoning and the case focused use of formal and experiential knowledge in practice. These were developed in terms of hypothesis testing, in particular the different processes involved: involving the concepts of progressive hypothesis development and comparative hypothesis assessment

The constituent conceptual elements of practice led theory were also novel. These were identified deductively from the dual theoretical analysis (of applied knowledge and social work). Hence the development of the practice paradigm of social work, involving a core of objectivism (in the definition of phenomena), limited voluntarism (in the perception of



human nature and the explanation of behaviour) and an approach reminiscent of the sociology of regulation (as the appropriate focus of practice), was derived deductively from the analysis of the social worker as state functionary and the examination of practice assumptions through the concepts of need and self determination. The principle of convergence, distinguishing between foreground and background knowledge and involving the principles of congruence and research validity is also novel and is intended to 'focus' formal knowledge as precisely as possible on practice. The concept of 'adequacy of fit' is one that arises in the context of a realist analysis and a case centred and case focused use of formal knowledge.

The development of the Compulsory Admissions Assessment Schedule was the first attempt to apply the principles of 'practice led theory' to the development of knowledge. As an exemplar of social science based assessment schedules, therefore, it was novel. Its methodology, using action research, was particularly useful for emphasising convergence, since the action researcher's problem orientation is a practical problem with theoretical relevance and the audience is both social scientists and practitioners. Its practice led approach was indicated in the book itself. The approach involved in the first instance theorising about the nature of the ASW role. This theory generated a set of questions which were used in the empirical analysis. This in turn generated CASH which was used in practice and subject to evaluation in the process of which further insights relevant for consistency in practice were obtained. This approach was explicitly 'practice led' in the sense indicated earlier; knowledge was developed within a framework of meaning consistent with practice; it involved focusing on problems confronted by social workers; it involved the principle of convergence.

This exemplar also showed how concept generation could be incorporated within this practice led approach. This is evident in the development of the 'mental health' and 'social risk' orientations and the 'presumption of risk'. It also showed how it could facilitate the (appropriate) standardisation of practice. Hence, the research on the use of CASH generated a classification of the main characteristics of different levels of severity of overall risk. This is of potentially major importance in developing criteria for distinguishing those for whom a section is expected from those for whom it is not. The practice led approach, as shown in this exemplar, is consistent with the development of theoretically informed practice, and practice relevant theory.

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81. Holland (1991) *op cit* uniquely does write about reflexivity, but rather as a practical than theoretical issue. His conceptual analysis is limited to a relatively brief definition, followed essentially by issues of application to practice.

# CLIENT SATISFACTION, BRIEF INTERVENTION AND INTERPERSONAL SKILLS

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*SUMMARY. There have been reservations expressed about the use of the concept of satisfaction in relation to clients' views of services received. There is, additionally, little research on client perspectives of mental health work. This article explores client satisfaction with brief intervention from workers based at a community mental health centre. A number of differences in the services received, and client's perceptions of these, are identified which relate clearly to the level of client satisfaction. These differences can be related clearly to interpersonal skills such as communication skills, empathy, listening and genuineness. It appears, then, that satisfaction does meaningfully represent client's experience, and this has implications for skills acquisition and use, an issue of fundamental importance for practice.*

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## Introduction

Taking the views of consumers seriously is now something of an article of faith in social work. As 'consumers of services', their judgements about the quality of help received are of great importance. Indeed, these judgements provide a significant means by which these services may be evaluated. Of course, this issue is complex. Some clients may be unwilling consumers, such as some child abusing parents or some young offenders, and as 'captive clients' their views of the service may have little to do with its quality. Who precisely is the consumer, furthermore, may be debated generally and in specific instances. When monitoring a child at risk, is it the child or the parents or perhaps the society (or more accurately the state) that empowers social workers to protect the child? Nonetheless the burgeoning client perspectives literature, involving those directly in receipt of services, bears testimony to the significance with which their views are regarded.



One area, however, where consumers' views have been rarely solicited in Britain, is that of mental health. Brandon (1981) has related this to the subject area: some actively resist the notion of accepting the views of those labelled mad or disturbed except for confirming diagnosis. Their problem (mental health), for some, appears to undermine the validity of their observations on their situation. There is, therefore, with a few notable exceptions, such as Fisher *et al.*'s (1984) study of area social work clients, a small qualitative study of crisis intervention (Davis *et al.*, 1985), and a more detailed comparison of the views of social work and community psychiatric nursing (CPN) clients (Sheppard, 1991), very little known about client experiences of intervention with mental health problems. This study seeks to extend our understanding of clients' perspectives by examining the views of 39 consumers of brief intervention at a Community Mental Health Centre. This appears useful for three main reasons: the paucity of research in the area of mental health, the focus it places on specialist workers in a mental health rather than area team setting, and the growing importance of community mental health centres as settings for the provision of community focused mental health services. In a more general sense it possesses one further advantage. The clients studied were individuals who had sought help voluntarily. It is likely, therefore, that responses would be less influenced by factors relating to the 'social policing' role involved with involuntary clients (although while being voluntary themselves, they may be aware of this 'social policing' role).

This study examines factors related to client satisfaction. Some reservations have recently been expressed about the use of client satisfaction as a means for evaluating intervention. These may broadly be divided into six. The concept of client satisfaction, some think, is too general to provide a meaningful guide to the way clients think. More detailed information is required on specific aspects of the clients' experiences (Locker and Dunt, 1978). Second, satisfaction may be related to the *way* a service is given rather than the *outcome* (positive or negative) of intervention (Rees and Wallace, 1982). Third, some clients may pronounce themselves satisfied knowing little of the alternatives available (Fisher, 1983). Fourth, in some cases merely asking people to rate something can produce favourable evaluations (Fisher, 1983). Fifth, individuals' comments are the prisoner of the moment: what they say on one occasion may be different from another occasion, possibly at a different stage of intervention (Sainsbury *et al.*, 1982). Finally, satisfaction may be related more to the clients' cultural background and expectations than their actual experience of intervention (Robinson, 1983). Fisher (1983, p.41) suggests that 'ultimately, then, the emphasis on the concept of satisfaction gives us only a very crude understanding of the reaction of clients'.

These reservations are permeated by at least three themes. First, although they are reservations they are made within a value commitment that it is important to take into account consumers' views. To make this commitment, as Shaw points out (Shaw, 1976, p.23) is to suggest at least an implicit conflict of interest between the consumer and producer (professional), with an associated assumption that worker and client are liable to see things differently. This, of course, may well be the case (Rees, 1978) but the tendency to emphasise difference rather than similarity may produce a 'mental set' where we assume a distance between the client and worker (or researcher) which does not reflect the degree, and areas, of shared meanings. There may, therefore, at times be a tendency to exaggerate the problems involved.

This 'conflict' assumption is closely related to a view that worker and client (and researcher) inhabit very different social worlds. Satisfaction may mean one thing to the researcher but quite another to the client. The background assumptions which influence the way clients would view or even understand the concept of satisfaction would thus considerably influence individual responses. Abrams (1976) and Shaw (1976) suggest that objective conditions and personal history are mediated through perceived conditions, expectations and aspirations to produce satisfaction levels. On this basis, user studies should take serious account of the social context of meaning and mutually shared meaning should not be taken for granted (Robinson, 1983). Indeed Douglas (1971) suggests that some assumptions held by social groups may frequently only be sensed by members of those groups rather than known explicitly and thus at times difficult to formulate explicitly.

A further theme relates to scepticism over the use of the term 'satisfaction' itself. Shaw (1976; 1984) suggests that different assumptions may lead researchers to ask questions which are of marginal importance to the client themselves. The client may, for example, regard social work as a bartering relationship entered into for the purpose of gaining specific material ends. The 'personal' relationship with the social worker seen as a means to these ends, may simply be viewed as an interference to be tolerated in order to receive the service. Focusing on the relationship may, at best, give only a partial picture. Rees and Wallace (1982, p.81) likewise point to differences between the quality of the relationship and (perceived) nature of outcome, and that statements of satisfaction may relate to either or both (or perhaps something else). Fisher (1983; Fisher *et al.*, 1986) commenting on research undertaken on children in care, goes so far as to suggest that the very concept of satisfaction itself may not properly represent clients' construction of intervention. Instead of satisfaction, which appeared inappropriate to describe

parents' views of their children receiving control they could not exercise themselves, they used the notion of 'moral sanction'. This referred to the appropriateness or acceptability (to the parents) of a range of ways of dealing with the problem he or she was experiencing.

It would be foolish to dismiss the themes which underlie reservations about 'satisfaction', which emphasise both social context and background assumptions. However, by focusing on these we may give insufficient weight to other factors of significance. First, while recognising social context, it is important to recognise that what goes on in the interview/intervention itself is significant: factors 'internal' as well as 'external' to the intervention have importance. There is, second, an issue of who has what kind of interest in which kind of issue or question. Much of the client perspective research has attempted to create a picture of the client's construction of their experience. In the process, the aim is somehow to get inside the 'world(s)' of clients, and, by writing about it, represent this world to those who are providers of services. This, it would be generally accepted, is of interest to the service providers. We may, however, also be concerned with issues of *direct* interest to the service providers themselves, particularly in terms of the tasks they set themselves. Such an approach would be evident in seeking clients' views of task centred work. The starting point is the issue of the efficacy of task centred work, generated from within the social work profession, and clients views represent one aspect of the examination of this approach. Some studies have been criticised for asking clients questions which are of interest to the profession, but which may be of peripheral interest to the clients. The problem here, perhaps, is not that such questions are asked, but that they are presented as if this represented clients' views of intervention unmediated by the particular interests of the profession or researcher. We should instead recognise that when asking questions the terms of which are set by the researcher or profession, that clients are responding within these terms. We would not thereby pretend that we have *the* 'clients' view', but that we have clients' views of a particular realm of issues of concern to the profession or researcher.

A third point is that by emphasising differences between clients and workers (and researchers) we may thereby underestimate the possibility of common ground - the extent to which meanings may be shared. England (1986) points to the significance of shared meanings to social life as a whole and social work in particular. Good social work practice, he thinks, is to a considerable degree, about achieving, as accurately as possible, shared meanings between client and worker. It is important to balance a recognition of difference with the possibility of shared meanings.

Finally, it may be that the concept of satisfaction itself has been aggran-

dised, and it is this which, to a considerable degree, is responsible for reservations about its usefulness. If, for example, we attempt to view it, as Rees and Wallace (1982) indicate, as a measure of both the quality of the professional relationship and the outcome of intervention, it may be that we are asking too much. We may instead accord it a more humble, yet perhaps a correspondingly more powerful role. The concept of satisfaction would be used to indicate a general sense in which the clients, overall, felt positive or negative about intervention. If we *start* at this point, then it may be possible to identify which elements, if any, of worker-client interaction are related to satisfaction. This study uses satisfaction in this way: to indicate a general sense in which clients felt positive or negative about intervention.

Given the reservations expressed it is most important to discover whether the concept of satisfaction has any use as a measure of the extent to which clients feel positive or negative about intervention. This article approaches this problem by relating levels of satisfaction to the nature of intervention and quality of (some) skills used by the workers. It focuses specifically on brief intervention which, I have observed elsewhere (Sheppard, 1991), may for both theoretical and practical reasons be differentiated from more extended intervention.

## Method

The study was carried out with clients of the Psychiatric Advisory Service (PAS) at the Nuffield Mental Health Centre, Plymouth. The methods used are discussed in great detail elsewhere (Sheppard, 1991). The clients were made up of three groups of 13 receiving intervention, respectively, from CPNs, social workers and jointly from CPNs and social workers. Each group was broadly representative of clients seen at the centre, based on an earlier survey (Sheppard, 1991). In the previous survey workers were asked to identify which problems from a range of mental health and social problems, they considered primary in each case.<sup>1</sup> These were divided into those with mental health primary problems (mental health cases) and those with social problems primary (social problem cases). The clients interviewed reflected the proportion of clients in each group who were mental health cases and those who were social problem cases. Excluded from consideration were clients who were assessed for compulsory admission under the Mental Health Act and those who, following assessment by PAS workers, were hospitalised. When these clients were excluded from the survey results, 12 (39%) social work clients were mental health cases and 19 (61%) were social problem cases; 24 (57%) CPN clients were mental health and 18 (43%) were social problem cases; and

34 (39%) of joint clients were mental health cases, while 54 (61%) were social problem cases. The clients in this study were divided up as follows:

Social work and joint work :	5 (38%) mental health cases,
	8 (62%) social problem cases.
CPNs :	7 (54%) mental health cases,
	6 (46%) social problem cases.

This stratification was broad. However, given the number of clients who, in previous studies refused an interview or for other reasons were unavailable, it was considered unwise to stratify in too great detail. The first client seen each day who was not assessed for compulsory admission or hospitalised informally and who received brief intervention (as defined by the agency, which in all these cases lasted under two weeks) was chosen. A letter was sent jointly signed by the senior CPN and social worker requesting a research interview and arranging a time. A stamped addressed envelope was included if they wished to refuse the interview. The refusal rate was high: 15 CPN, 13 social work and 17 joint clients refused, and this should be borne in mind when examining the results. All clients were interviewed within a month of intervention; all but three between two or three weeks of seeing the worker. The results reported were based on fully structured instruments, which are reproduced elsewhere (Sheppard, 1991) a method which has been used in other studies (Paykel and Griffiths, 1983; Corney, 1981; Sainsbury *et al.*, 1982). Additionally, the workers completed a fully structured questionnaire, with classification of problems and activities identical to those of the client, to facilitate comparison. This also has been reproduced elsewhere (Sheppard, 1991). Client satisfaction was measured by a five fold classification: very satisfied, quite satisfied, neither satisfied nor dissatisfied (neutral), quite dissatisfied and very dissatisfied. The data are analysed in two ways: first using a satisfied - not satisfied dichotomy. Satisfied here refers to quite or very satisfied, and not satisfied to the rest. The second involves the full range of measures, which is used where such information provides something additional to the satisfied - not satisfied dichotomy. The clients were asked about their degree of satisfaction at the beginning of the interview in order that their assessment was not influenced by their more detailed consideration of intervention, which occurred with subsequent questions. The subjects of this study were those who received agency defined brief intervention. The agency divided clients into those who received brief help and those who received short or long term caseload intervention. The former group overwhelmingly involved people who received intervention lasting under a week and where there were one or two face to face interviews with the client. On the rare occasions these interventions lasted beyond a week this was invariably only

to complete processes (such as contacting outside agencies) which had been initiated within that week.

### Results

Clients were almost evenly divided by sex: 20 male and 19 female. Twenty six (68 %) were aged 20 to 44, three were aged over 65 and the rest were aged between 45 and 64. Twenty one (54%) clients were married or cohabiting. Eleven clients (28%) were owner occupiers, 14 (36%) lived in council accommodation and the rest were lodgers or lived in hostel or privately rented accommodation. Four clients had retired and 16 (45% of those of working age) were unemployed. This group of clients, in a number of respects, therefore, was socially disadvantaged.

### CASE CHARACTERISTICS

Satisfaction may first be related to clients' problems. Slightly more of the 17 mental health cases (59%) than the 22 social problem cases (50%) were satisfied, a far from significant difference<sup>2</sup>. Detailed analysis, using the full range of measures from very satisfied to very dissatisfied likewise shows no significant differences in level of satisfaction according to the type of case. Not all cases where a mental disorder was considered by the worker to be present were defined as 'mental health cases' since a social problem might be regarded as primary. It is useful, therefore, to relate satisfaction to mental health status. Mental ill health was considered present in 21 cases and absent in 18 cases. Clients with a mental disorder were slightly more frequently satisfied than when it was absent, 12 (57%) of the former group compared with nine (50%) of the latter pronouncing themselves satisfied. This was not significant. Workers were also asked to divide those with mental health problems into definite and borderline cases.<sup>3</sup> Results are shown in Table 1. Although actual numbers are quite small, differences are just below significance (using Fisher's exact test). This is emphasised still more with the full range of measures (very satisfied to very dissatisfied). Five of those with a borderline disorder were quite or very dissatisfied compared with only one with a definite disorder. The reason for this configuration is not clear, but may be investigated further.

This can be undertaken in relation to the concept of case complexity, involving three measures: the number of problems per case, the number of severe problems and the number of cases with multiple problems. Only one (not satisfied) client had no social problems. However, 12 (60%) of the 20 clients with one or two problems were not satisfied with intervention,

compared with only five (28%) of the 18 clients with more than two problems ( $p=0.07$  when those with two or less problems are compared with those with more than two). Furthermore, examination of problems which workers considered to be severe shows that 10 (59%) of the 17 with no severe problems were not satisfied compared with only eight (36%) of the 22 with one or more severe problems. Although not reaching significance, these data indicate that those with the most severe problems - measured by the number and severity of social problems and 'caseness' of mental illness - were more likely to be satisfied than those with less severe problems. It is the 'in-between' clients - those with borderline mental illness, less than two social problems (though not without any social problems), and without severe social problems who were least likely to feel satisfied with intervention. It may be that their problems were severe enough to cause great distress, while nonetheless leaving them strong enough to withhold more positive comments on the worker.

Further evidence supporting this view is provided by clients with multiple problems. Individual problems were divided up into three broad areas: practical, emotional and relationship and physical ill health.<sup>4</sup> Those with problems in more than one broad area were defined as clients with multiple problems. Rather more clients with multiple problems, 11 out of 18 (61%) than those without multiple problems - 10 out of 21 (48%) - were satisfied with intervention. Although not significant these differences suggest the less severe group were less positive about intervention.

However, the picture is more complex when the full range of satisfaction measures is used. Six of the seven clients with multiple problems who were not satisfied were quite or very dissatisfied, compared with only 2 of the 11 clients without multiple problems (the rest were neutral). There was a tendency to extremes of satisfaction and dissatisfaction amongst clients with multiple problems with greater 'centring' around neutrality in other clients. Furthermore, 10 of the 13 clients with 2 or fewer problems were neutral while all 5 of those clients classified 'not satisfied' with more than two problems (28% of total) were quite or very dissatisfied. Likewise, in relation to severe problems, 6 of the clients with no severe problems (35%) compared with four clients with one or more severe problems (18%) were neutral. The difference between these two groups in unsatisfied clients, therefore, is almost entirely the result of those who were neutral. It is difficult, therefore, to maintain that case characteristics were related directly to satisfaction.

There were no significant differences in relation to the presence of problems from particular broad areas. Eight out of 14 clients with practical problems (57%) were satisfied compared with 13 out of 25 (52%) without them. Likewise, 19 of the 35 clients with emotional and relationship problems

(54%) were satisfied compared with 2 of the 4 without these problems. Finally, slightly more of those with physical health problems - seven out of ten - were satisfied than those without these problems (14 out of 25, 48 %). This was not, however, significant .

#### WORK UNDERTAKEN

Satisfaction may also be related to the kind of work undertaken. This may be examined in terms of workers' activities. There were no significant differences in level of satisfaction according to whether or not particular activities were undertaken. Indeed across all activity areas the data are remarkable for the similarities in level of satisfaction whether or not particular activities were performed. Both clients subject to one activity only were not satisfied, compared with four out of 6 receiving two activities, 9 of the 22 receiving three activities, and 3 of the 5 receiving four activities (not significant).

These activities may be divided into broader roles (assessor, drug administrator, psychosocial treatment agent, teacher-counsellor and broker) (Whittaker, 1974).<sup>5</sup> Undertaking particular roles was not significantly related to client satisfaction. However, did particular roles make a difference in relation to particular problem areas? The broker role, with its elements of advocacy and resource mobilising, appears particularly relevant to practical problems. Likewise, the psychosocial treatment agent role, involving psychodynamic work, ventilation and emotional support and monitoring appears relevant to emotional and relationship problems. Table 2 shows the results using the full range of measures from very satisfied to very dissatisfied. The psychosocial treatment agent role made no difference to satisfaction amongst clients with emotional and relationship problems. It may be that this role was only required on some occasions and on those occasions when clients considered it necessary it was undertaken. The broker role with practical problems presents a different picture, with significant differences according to whether or not it was taken. However, the picture is not simple. Clients were more likely to be dissatisfied when the role was absent, but equally were more likely to be very satisfied. Hence comparing quite satisfied and neutral with extremes of very satisfied, quite dissatisfied and very dissatisfied the differences are significant (Fisher exact probability test two tail=0.003) These extremes may indicate that on some occasions clients considered this role unnecessary, but when not performed and considered necessary they were dissatisfied.

This argument has some substance. Clients were asked if they would have liked the worker to have undertaken activities other than those they performed. The results are shown in Table 3. Those clients who did not wish



for an alternative activity were significantly more satisfied than those who did. Indeed the latter group was the only one where active dissatisfaction was expressed. Differences are likewise significant when simply divided up between satisfied and not satisfied clients ( $p=0.001$ ). Indeed, there was a greater dissatisfaction displayed by clients when workers failed to undertake desired activities in a number of areas: discussing future options, monitoring, education in social skills, psychodynamic work and advocacy.

This is reflected in comments made by clients. One woman, who had been given information about local supports, commented that:

...she offered a few suggestions about voluntary work, but its not what I needed - I knew that. I needed moral support - to work on my emotional problems. I didn't specifically ask her for this - I expected she would identify it - for her to offer it to me.

Another woman wanted to move from her flat and had had her expectations raised by her (referring) GP who had said that workers would support her application. They, however, did not, and failed to give a reason for this:

All they said about it was that I'd done the house up and that I should go out and see people more - otherwise I'd have the same problem of doing the place up as I had when I moved in. They didn't contact housing though - not as far as I know anyway.

Contrast the critical tone of these comments with the more positive responses of those who did not feel they would have benefited from alternative activities. One client, for example, was surprised by the skills displayed:

She was better than I expected. She knew more than I thought. Its difficult to say exactly what. They seemed to know about handling emotions and things.... She was very perceptive. She seemed able to draw things out of me. I became aware of things I had not really thought of before.

The work undertaken may also relate to the approach taken to intervention. Clients were asked whether or not they considered workers had been open in their dealings with the client particularly in relation to providing them with appropriate and relevant information about their situation, and in telling them how they (the worker) viewed their situation. This was done in relation to five problem areas: practical and financial, child care and familial, personal functioning, social relations and network and ill health. Workers were considered not be open in one or more of these areas in only three cases. However, using the full range of satisfaction measures, these clients were

markedly less satisfied: one was quite dissatisfied, and two very dissatisfied. In cases where workers were open 10 (28%) were very satisfied, 11 (31%) quite satisfied, 10 (28%) neutral, 3 (8 %) quite dissatisfied and 2 (5%) very dissatisfied (Mann Whitney U test,  $p=0.07$ ). Lack of openness was identified in both practical/financial and personal functioning problems in two cases and in child and family care and social relations or network problems in one case. Although lack of openness, therefore, was rare, it was clearly associated with dissatisfaction.

The perception of worker openness derived, from the comments of clients, largely from a sense of the kind of person they (the worker) was:

The bloke I saw - he was just so good at what he did... from the start he was such a friendly person, he was someone you could trust - he was someone who didn't impose himself on you.

Another commented that

She strikes me as sincere.... I feel I can trust what she's saying - she's pretty honest with you.

Compare this with a woman who had a poor relationship with her husband and financial problems and found it difficult to cope, who condemned

...their whole attitude. They seemed rather self centred - they weren't really interested though they wouldn't admit it... All she said was if you get any more problems we'll give you this card and you ring us.

Clients were also asked, over the same five areas, about their involvement in planning, and carrying out a response to their problems. There were three divisions for each area : mainly or entirely the worker, equal responsibility, and mainly or entirely the client. Table 4 shows the number of cases where, in at least one area of either planning or action responsibility was taken mainly or entirely by the worker. Although differences were not significant, clients were more frequently satisfied where this was the case than where it was not. This was consistent for both planning and action: identical data emerged in relation to planning, and in both cases when action was undertaken in at least one area by the worker the clients were satisfied, compared with 19 of the 37 occasions when this was not the case. This, it should be emphasised, did not mean all the planning and action in these cases was primarily undertaken by workers. In all these cases, there were areas of planning and action carried out equally or primarily by the client. These data

indicate, however, that when a mix of responsibility occurred clients were more likely to be satisfied.

#### AGREEMENT BETWEEN CLIENT AND WORKER

The degree of agreement between client and worker was measured in relation to two elements of intervention: problems defined and work undertaken. Problems were examined in terms first of the extent to which clients identified problems identified also by the worker, and second in terms of concordance and discordance between client and worker. While the former identifies the frequency with which clients agreed with workers' definitions of problems, in the latter case discordance occurred where the worker identified a problem the client did not or *vice versa*. The scope for discordance (the latter case) was greater, therefore, than that for disagreement (the former case).

There were no significant differences in the level of concordance and discordance in any individual problem area according to the level of client satisfaction. This was the case also in relation to the extent clients identified problems also identified by the workers. Table 5, however, provides a much clearer picture. This presents an aggregation of all instances of concordance and discordance, and agreement or disagreement in relation to specific problem categories which lay within each broad problem area. Clients agreed with workers in the majority of problems identified by the latter, although clients did not define as problems a significant minority of problems identified by workers. However, although there was slightly greater agreement when clients were satisfied, the difference between satisfied and dissatisfied clients was small. The full range of measures of satisfaction shows that while there was noticeably greater agreement when clients were very satisfied, differences between other levels of satisfaction, apart from very dissatisfied, were minor. However, workers showed far more concordance with satisfied than with dissatisfied clients. This result is primarily because of differences between satisfied and not satisfied client groups with emotional and relationship problems, which anyway represented the bulk of the problems identified by clients and workers. However, there is no simple linear relationship between level of satisfaction and degree of concordance. Hence concordance was greater amongst quite satisfied than very satisfied clients, and amongst quite dissatisfied compared with 'neutral' clients. The configuration of the data, where not satisfied clients did not differ greatly from satisfied clients in their level of agreement on problems identified by workers, but these not satisfied clients displayed far greater discordance than satisfied clients, shows that lack of satisfaction was related to a considerable degree to problems identi-

fied by clients but not by workers. This 'lack of recognition' may be doubly frustrating for the client: workers' perspective of clients' circumstances would exclude problems clients genuinely felt they had and, if problems were not recognised, they could not actually be tackled.

The effect this could have is evident in some clients' comments. One woman said:

They didn't seem to realize my difficulties - like with my financial problems. All they said was that we all have financial problems - like with mortgages or whatever - but its not the same when you don't get much money. How are you going to save when you're on social security?

Another said:

They just seemed to go through the motions. I think they classified me as 'she's not really got problems' ....they should be trying to understand how you feel. I've had the opposite reaction of 'Oh well dear', pat you on the head kind of thing. It makes you mad, you feel like hitting out at them.

Client-worker agreement about problems on the other hand, could enable the development of meaningful work:

She seemed to understand what I was telling her. She did give me advice - saying it was early days in the relationship (with her partner) but she was able to listen while I was able to talk to her and I could work out what was happening.

Clients were asked to indicate which problems they thought *the worker* considered them to have and also which activities the worker had carried out. The purpose of this was not, as with the previous data, to compare clients' and workers' definition of the situation, but to obtain some indication of the effectiveness with which workers *communicated* their definition of the clients' problems, and work undertaken, to the client. Effective communication would be shown by the accuracy with which clients identified workers' views and activities undertaken. Clients were asked not to guess when they were uncertain. Of course, cases where clients did not know the worker's definition did not mean that they had not *attempted* to communicate this, just that the client had not 'taken it on board'. These data are quite unambiguous. (Table 6). Satisfied clients were far more aware of workers' definitions of their problems and roles adopted than dissatisfied clients. Indeed the full range of measures of satisfaction (from very satisfied to very dissatisfied) shows a

fairly close relationship between level of satisfaction and degree of awareness. In relation to problem areas the gap between satisfied and not satisfied clients was roughly equal between practical and emotional-relationship problems, but slightly greater with ill health. Greater differences are evident between different roles: apart from the broker role the gap varied between 13 and 22%, although far more clients were aware of the psychosocial treatment agent role than that of teacher counsellor.

### OUTCOME

The final area related to satisfaction was the clients' view of the outcome of intervention. This was based on two measures, psychiatric outcome and social problem outcome. Outcome with brief intervention emphasised the notion of the worker's helpfulness with social problems and improvement with mental health problems. Numerical values were attached to the degree of help or improvement as follows.

Mental health problems		Social problems	
No improvement	0	No help	0
Improved	1	Helped	1
Resolved	2	Solved	2

The measures only examined positive change. In relation to mental health the notion of 'improvement' was used to indicate where help was given (as was 'helped' for social problems), but given the brevity of intervention it was more a measure of initial reduction in intensity or number of symptoms. Both 'resolved' for mental illness and 'solved' for social problems were used to indicate where the problem had been reduced to a point where it was no longer considered a problem. The index of change was as follows:

$$\begin{array}{rcl}
 \text{Sum of score of all} & & \text{The number of cases} & & \text{Index} \\
 \text{cases where the} & & \text{where the problem} & = & \text{of} \\
 \text{problem was identified} & + & \text{was identified} & & \text{change}
 \end{array}$$

These methods are discussed in greater detail elsewhere (Sheppard, 1991). Table 7 shows satisfaction related to psychiatric and social outcome. There is little ambiguity, either with the satisfied-not satisfied dichotomy, or with wider measures of satisfaction. On every measure of psychiatric and social problem outcome (except ill health) the outcome for satisfied clients was considerably more positive than for dissatisfied clients, with the gap widest in relation to emotional and relationship problems. There was,

furthermore, a clear relationship between level of satisfaction and overall measures of both psychiatric and social problem outcome. Outcome was most positive for very satisfied clients and least positive for very dissatisfied clients. Where clients were satisfied the most positive outcomes were associated with emotional and relationship problems. The complete lack of any positive outcome is noticeable in relation to very dissatisfied clients. Clients' level of satisfaction, therefore, makes a great deal of sense in relation to their evaluation of outcome.

This is reflected in comments by clients when asked what difference intervention made to them.

One man suffering severe anxiety said

It made a lot of difference - things would have got out of all proportion..... I was on tranquillisers and I could have ended up in Moorhaven (psychiatric hospital) if I hadn't seen them.

A woman spoke similarly:

If I hadn't gone I would have just sat and stewed and it would have taken a lot longer to get over. I mean you've got your parents to talk to, but they're very subjective.

Compare this with comments of those who felt there had been no improvement:

...there was nothing really that they did that helped me. In fact I felt worse after they had been.

Another commented, similarly, that intervention made:

...no difference at all. Except it cost me money. I can't afford ten or 11 quid for taxi fares.

Another woman living in fear in a poor vandalised flat said of the difference intervention made:

None really. They didn't actually do anything... I swear if I have to stay here much longer I'll slit my wrists. I can't stand it.

### Discussion

This study, as stated at the outset, is not presented as a refutation of studies which emphasise the social context or personal construction by clients of their experience of intervention. Rather it sought, by examining factors relating to the nature and outcome of intervention, to understand the relationship, if any, between satisfaction and those factors analysed. It possesses, therefore,

more an 'internal' (to the intervention process) rather than 'external' (relating views to social context) focus. While recognising this, however, it remains the case that some relationships *were* identified between factors examined and degree of satisfaction. These in turn may be related to interpersonal skills.

A clear message is given by these results: statements by clients about their degree of satisfaction should be taken seriously as an indication of their experience of intervention. When the research was devised global statements of satisfaction were intended to be used as general indications of the extent to which clients felt positive or negative about intervention. This view has been vindicated, although results are not simple. Case characteristics had little bearing on the degree of satisfaction: hence the nature of the clients problems did not affect satisfaction, although clients with problems of middling severity may be less inclined to be positive. There were also no overall noticeable differences related to the nature or amount of work undertaken. However, there is limited evidence from brokering activities with practical problems that undertaking roles appropriate to problems confronted is important. More significant, however, is the performance of tasks which clients considered necessary. Where these activities were not undertaken clients were far more likely to be dissatisfied. The definition of the client's situation was also important: satisfied clients displayed a greater degree of concordance with workers in their definition of their problems than dissatisfied clients. Satisfied clients also displayed greater awareness of workers' definitions of their problems and of the work undertaken on their behalf by workers. A perceived lack of openness by workers was significantly associated with dissatisfaction. Finally, the clients' perception of outcome was closely related to satisfaction. Statements of satisfaction and dissatisfaction, therefore, provide a meaningful shorthand for their experience of intervention. However, simple dichotomies of satisfaction - dissatisfaction are perhaps less adequate than a wider range of measures indicating the *degree* of satisfaction. In particular they should include a 'neutral' or 'non committal' category which gives expression to the views of clients who were neither satisfied *nor* dissatisfied. Common sense suggests that a purely dichotomous approach is artificial and this is confirmed by the number of clients who chose to be neutral.

What, however, are we to make of these results in terms of practice? Before examining some of their implications we should note Shaw's (1976; 1984) warnings about basing policy recommendations on clients' views. In particular he is concerned about other groups expressing views diverging from those of one study. It is worth noting in this context that a study of more extended intervention, while varying from this study in some factors, also

identifies significant relationships between satisfaction and the nature of intervention, and hence is broadly consistent (Sheppard, 1991a). Second, views should be relatively stable over time. This was, of course, a retrospective study. However, this study was less concerned with using satisfaction as an absolute statement of clients' views of intervention. It is possible that at different stages of intervention clients express different levels of satisfaction (although this study of brief work precludes this kind of examination). However, this study was concerned to investigate, when the client expressed satisfaction or dissatisfaction, the relationship between different levels of satisfaction and the nature of intervention.

Although two occupations were involved there is no reason to believe that, as guides to practice, the results are not relevant generally to interpersonal work. It should be remembered at the outset that this study represents the views of clients who had received brief intervention, usually less than a week, and hence contact with the worker was limited. Nonetheless, it provides empirical evidence about the need for certain skills if workers are to maximise client satisfaction. It was clearly not the kind of case, but the workers' *approach* and outcome which was significant. This is best understood in terms of factors associated to a greater extent with the absence of satisfaction rather than satisfaction. At the core of many factors appears to be problems of communication. Clients who were not satisfied showed less awareness of the worker's view of their problems and of the actual work undertaken on their behalf. In the latter case this appears to have gone beyond communication problems; dissatisfied clients were more frequently unaware of activities which were undertaken actually with them, and which to be performed at all necessarily required their participation. This is most obvious with the teacher-counsellor role. This raises the question of how effectively this work was performed, when the participating client appeared unaware it had taken place! Nonetheless, the worker had clearly not *effectively* communicated with the client about this work. The higher level of discordance between client and worker associated with dissatisfaction, emphasised a conflict in their definition of the client's problems. The client, however, may not agree with the worker's view of their problems, but this was only slightly more evident with dissatisfaction. It is when, taking the group as a whole, workers fail to recognise as problems those problems which clients considered themselves to have that they were more likely to be dissatisfied. In these circumstances clients would be likely to feel workers were not properly 'in touch' with their real situation. A perceived lack of openness by the worker - clearly an aspect of communication - was also associated with dissatisfaction.

Communication skills are widely recognised as core to interpersonal



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relations, the foundation upon which intervention is based (Haines, 1981, p.170; Speight, 1986, p.86). This itself has a number of dimensions relating to giving and taking messages, checking out meanings, awareness of non-verbal as well as verbal communication and so on (Compton and Galloway, 1978; Brown, 1973; Smith and Bass, 1982). However, even this fails to give credit to the full range of potentially relevant skills. Listening, empathic understanding and individualising, for example, have clear relevance. The problem of discordance may arise because worker and client genuinely disagree over the client's problems. Does this mean that the worker is the prisoner of the client's definition of their problems if the client is to be satisfied? Not necessarily. Before unnecessarily finding themselves discordant with the client, it is possible to negotiate meanings with them in order to gain some kind of shared definition of problems. This may involve the age old social work principle of 'starting where the client is'. The ability to listen-to 'listen and know what I mean' (England, 1986, p.23) - is a clear element of starting where the client is. Empathic understanding "the power to feel imaginatively the experience of the other person..... to 'get on the same wavelength' as them" (Haines, 1981, p.152) is closely associated, and required if the worker is to be aware not only of the client's problems but also the way they experience these problems, and the meaning these problems have for them. Problems do not occur in some objective abstract realm, but are placed within a client's personal biography and are subjectively experienced and understood. These brief examples of potentially relevant skills serve to emphasise the enormous complexity of the interpersonal situations in which two (or more) people come together to work on particular problems. These are not, of course, the only potentially relevant skills. Therapeutic skills such as clarification, a process enabling clients to re-order their thinking about themselves and their situations (Middleman and Goldberg, 1974, p.122) or the promotion of self-understanding (Haines, 1981, p.91) may on occasions help clients reinterpret problems in ways which bring their definitions closer to those of the worker.

A lack of openness was also significantly associated with dissatisfaction. Openness, genuineness and authenticity have also been extensively discussed in the literature (Perlman, 1979, p.60; Barry, 1984, p.141). They are closely related: the worker openly providing information requested, and when appropriate initiating information sharing (Kadushin, 1983). Of course, the research identified client *perception* of openness: it's lack indicating a felt lack of trust, of secretiveness on the part of the worker. It may be that these workers were not, in fact, entirely open: but this serves again to emphasise the importance of effectively communicating openness. Finally, the data gener-

ally indicate the importance of approaches associated with task centred and contract work (Reid, 1978; Corden and Preston-Shoot, 1987). Key elements of this are client participation in defining and carrying out intervention, clarity in identification of problems and tasks, and explicit consensual agreements.

Intervention with psychosocial problems is a complex process. The brevity of intervention may suggest a greater opportunity for communication difficulties than more extended intervention, with its greater opportunity for mutual definition sharing (although this issue requires investigation). However, this article has both shown that client statements of satisfaction represent a meaningful assessment of their experience, and that, if satisfaction is used as a means for evaluating intervention, it provides strong support for the need for the development and use of a variety of skills and practice competencies.

#### Notes

1. These were specialist mental health workers, who were used to identifying mental health problems in their clients. There were, therefore, two classifications. The first, of mental ill health, included problems such as schizophrenia, depression, mania and so on. The second, of social problems included, for example, financial, housing, marital, social relations and so on. It was possible, therefore, for a woman considered to have marital problems to be classified as depressed. The worker may consider the marital problems to be primary, perhaps because the marital problems are responsible for their depression. Alternatively they may consider the depression primary, where for example, marital problems arose largely because of the depression.
2. Except where otherwise stated, the chi squared test was used to test for significance.
3. If a case was defined as 'definite', the person would have to be sufficiently disturbed that a psychiatrist would not be surprised to see them in out-patients (or hospitalised) and likely to benefit from psychiatric treatment. Borderline cases had symptoms of a disorder, and their symptoms were not sufficient in number or severity to be rated as cases. The distinction, then, was one of severity.
4. Practical problems were : housing, financial, employment and home management.  
Emotional and relationship problems were : marital, child abuse or neglect, other child care problems, loss/separation, other social relations or isolation problems, emotional and delinquency or criminal behaviour.  
Ill health problems were : major physical ill health or disability and minor physical ill health or disability.

5. Whittaker's divisions were psychosocial treatment and support agent, teacher-counsellor, broker and advocate. To these were added assessor, because of the importance of this function and drug administrator, significant in the CPN role.

Activities were defined as follows:

Assessor: section assessment, other assessment and information gathering

Drug administrator: one activity

Psychosocial treatment and support agent: psychodynamic work, ventilation and monitoring.

Teacher-counsellor: education in social skills, providing information and advice, discussing future options.

Broker-advocate: mobilising resources, advocacy on behalf of the client.

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**Table 1: Mentally ill clients; satisfaction related to definite and borderline status.**

	Satisfied	Not satisfied
Definite	7 (88%)	1 (12%)
Borderline	5 (38%)	8 (62%)

*Two tailed p = 0.07 (Fisher's exact test)*

**Table 2: Impact of broker role on satisfaction for clients with practical problems and impact of psychosocial treatment agent role on clients with emotional problems.**

	Very satisfied	Quite satisfied	Neutral	Quite dis-satisfied	Very dis-satisfied
Broker role	-	3 (60%)	2 (40%)	-	-
No broker role	4 (45%)	1 (11%)	-	3 (33%)	1 (11%)
Treatment agent	5 (25%)	6 (30%)	5 (25%)	2 (10%)	2 (10%)
Not treatment agent	3 (20%)	5 (33%)	4 (27%)	2 (13%)	1 (7%)

N/S

**Table 3: Clients' desire for alternative actively related to satisfaction.**

	Very satisfied	Quite satisfied	Neutral	Quite dis-satisfied	Very dis-satisfied
Alternative activity wanted	1 (6%)	2 (13%)	5 (31%)	4 (25%)	4 (25%)
Alternative activity not wanted	9 (39%)	9 (39%)	5 (22%)		

*2 tailed p=0.033 Mann Whitney U test.*

**Table 4: Division of responsibility for planning and action related to satisfaction.**

	Satisfied	Not satisfied
Mainly/entirely worker in at least one area.	8 (73%)	3 (27%)
No area where mainly/entirely worker.	13 (46%)	15 (54%)

N/S

**Table 5: Concordance/discordance and agreement/disagreement between client and worker.**

	Satisfied		Not satisfied	
	Concord	Discord	Concord	Discord
Practical	7 (30%)	16 (70%)	7 (32%)	15 (68%)
Emotional	36 (63%)	21 (37%)	19 (38%)	31 (62%)
Ill health	5 (38%)	8 (62%)	-	5 (100%)
<b>Total</b>	<b>48 (52%)</b>	<b>45 (48%)</b>	<b>26 (34%)</b>	<b>51 (66%)</b>

	Agree	Disagree	Agree	Disagree
	Practical	7 (70%)	3 (30%)	7 (64%)
emotional/ Relationship	36 (78%)	10 (22%)	19 (76%)	6 (24%)
Ill health	5 (71%)	2 (29%)	-	3 (100%)
<b>Total</b>	<b>48 (76%)</b>	<b>15 (24%)</b>	<b>26 (67%)</b>	<b>13 (33%)</b>

	Very satisfied		Quite satisfied		Neither		Quite dis-satisfied		Very dis-satisfied	
	T	%	T	%	T	%	T	%	T	%
Concordance - discordance	49	47	44	57	38	34	19	47	20	20
Agreement- disagreement	28	82	35	71	17	76	14	64	8	50

*T is total number of instances of (a) concordance and discordance; and (b) total number of instances of agreement and disagreement.*

*% is (a) Proportion of instances of concordance and discordance which were concordant; and (b) proportion of instances of agreement and disagreement where agreement occurred.*

**Table 6: Client awareness of workers definition of their problems and of activities undertaken by the worker.**

	Satisfied		Not satisfied							
	Aware	Not aware	Aware	Not aware						
Practical	6 (60%)	4 (40%)	5 (50%)	5 (50%)						
Emotional/ relationship	29 (63%)	17 (37%)	13 (50%)	13 (50%)						
Ill health	5 (71%)	2 (29%)	0 (0%)	3 (100%)						
<b>Total</b>	<b>40 (63%)</b>	<b>23 (37%)</b>	<b>18 (46%)</b>	<b>21 (54%)</b>						
Assessor	12 (80%)	3 (20%)	8 (67%)	4 (33%)						
Psychosocial treatment										
Agent	12(100%)	0 (0%)	7 (78%)	2 (22%)						
Teacher- counsellor	15 (56%)	12 (44%)	10 (42%)	14 (58%)						
Broker	3 (75%)	1 (25%)	0 (0%)	3(100%)						
<b>Total</b>	<b>42 (71%)</b>	<b>16 (29%)</b>	<b>25 (52%)</b>	<b>23 (48%)</b>						
	Very satisfied		Quite satisfied		Neither		Quite dis- satisfied		Very dis- satisfied	
	T	%	T	%	T	%	T	%	T	%
Problems	28	71	35	57	17	59	14	43	8	25
Role	28	86	30	60	25	56	11	45	12	50

*T is total number of problems identified by workers.*

*% is proportion of problems identified by workers of which clients were aware.*



**Table 7: Satisfaction related to outcome: indexes of change**

	Satisfied	Not satisfied			
Psychiatric outcome	0.50	0.07			
Social problem outcome	0.48	0.09			
Practical	0.31	0.04			
Emotional relationship	0.53	0.09			
Ill health	0.09	0.00			
	Very satisfied	Quite satisfied	Neither	Quite dis-satisfied	Very dis-satisfied
Psychiatric outcome	0.56	0.43	0.14	0.00	0.00
Social problem outcome	0.68	0.28	0.14	0.10	0.00
Practical	0.33	0.30	0.00	0.25	0.00
Emotional relationship	0.71	0.36	0.14	0.08	0.00
Ill health	0.25	0.00	0.00		0.00

# Theory for Approved Social Work: the Use of the Compulsory Admissions Assessment Schedule

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## SUMMARY

In his work on compulsory admissions under the Mental Health Act, 1983, Sheppard (1990) developed the Compulsory Admissions Assessment Schedule (CASH) in response to identified knowledge deficiencies and as a means for operationalizing a knowledge base distinctive to social work. While subject to detailed theoretical development it was not tested in practice. This article examines the use of CASH in practice, and the results have implications for compulsory admission assessments. This paper indicates that CASH is practical to use, that, although there are some grey areas, CASH on the whole distinguishes clearly between possible sections and those not possible to section, that dangers, hazards and risks are clearly identified, that rating is consistent with the seriousness of dangers identified, that cumulative use of CASH may help develop accountability, and that social work evaluation of CASH is positive. This article concludes that there are considerable benefits from the use of CASH, that ASWs should be trained properly in its use, and, more widely, that these results, together with Sheppard's (1990) original research and theoretical development, indicates that, when conducted appropriately, social science can directly, and beneficially, be applied to practice.

Social work has major responsibilities under the Mental Health Act, 1983 (the Act). Under this approved social workers (ASWs) may act as applicants for admission to hospital alongside doctors who provide medical recommendations. A person (defined by the Act as a patient) may be compulsorily admitted if they are suffering a mental disorder and admission is in the interests of their own health or safety or for the protection of others (assuming they will not enter hospital voluntarily). Admission may be for as long as six months (section 3) and section 3 is renewable. This is an area both of major importance, and complexity

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of judgement, for social work, involving, as it does, issues of civil rights, and the balance of the treatment needs of the patient against issues of personal liberty.

Recent research has demonstrated the critical role to be taken by approved social workers (ASWs) independent of medicine, in section assessments (Sheppard, 1990, 1991*b, c, d*; Barnes *et al.*, 1990; Fisher *et al.*, 1987). A consistent theme is the importance of social factors, both in the form of social disadvantage such as race and gender and the social process of assessment in understanding sections. However, there is evidence that ASWs have been disadvantaged by the lack of a formal knowledge base which can provide a balance to medicine in the tension between medically based and social assessment (Sheppard, 1990). Its consequence is presented in two alternative orientations reflecting the 'assumptive world' of participating professionals. The first, a 'mental health orientation' is characterized by greater emphasis on mental health status than the health or safety of the patient or protection of others. This has a number of associated tendencies: towards a presumption of risk, where the presence of mental illness was regarded as inherently risky, a lack, on some occasions, of clarity in assessment and a wide 'threshold of risk' with inconsistencies in some cases between ASWs assessing patients. The 'social risk' orientation, by contrast, is characterized by equal status given to mental disorder and the health or safety of the patient and protection of others, a lack of preconceptions of risk, and a requirement of clarity in assessment of risk. Sheppard (1990) speculated that this approach, appropriate to social work, would reduce the 'threshold of risk'. It was also evident from the research that development of a formal knowledge base was of great importance in this critical area of social work.

The compulsory admissions assessment schedule (CASH) was developed in response to deficiencies in the knowledge base available in this critical area of social work. Through the development of the concept of social risk and other concepts, its aim was to provide a knowledge base distinctive to social work. It is intended to be used by ASWs when carrying out their assessments as a critical part of the assessment process. However, although subject to detailed theoretical development, CASH was not actually tested *in practice*. This is of considerable importance because of its relevance to the adequacy of practice in the critical area of compulsory admission assessment. This article reports on the use of CASH by ASWs in assessments for compulsory admission over a one year period.

The assessment of CASH was based on a number of questions informed by expectations noted by Sheppard (1990) in its theoretical development.

1. Is CASH an instrument which is practical to use in practice situations?
2. Does CASH discriminate clearly between circumstances considered to require sections from those which do not?
3. Is there internal validity in the use of CASH (Oppenheim, 1986); that is, does the outcome make sense in relation to factors identified in each case?
4. Is the use of CASH associated with clarity in the assessment of risk?
5. To what extent does CASH induce consistency between ASWs in their assessment?
6. Does CASH provide the opportunity for wider accountability by ASWs?
7. Do ASWs consider CASH makes a positive contribution to their assessments?

## METHOD

Sheppard argued that the criteria relating to the health or safety of the patient and protection of others were those most significant for understanding the distinctiveness of the role of the ASW, and CASH concentrated on this as the focus for ASWs' knowledge base. Extensive discussion of the construction, definitions and use of CASH are given elsewhere (Sheppard, 1990) and summarized in the Appendix. The analysis took the form of action research (Clark, 1972), since methods allowed comparison with Sheppard's (1990) previous research. Three other elements were also involved. First, assessment was made against goals identified by Sheppard, such as consistency in rating. Second, 'internal validity' was assessed by, for example, examining rating against the type of dangers identified. Third, the ASWs' views were sought.

CASH is a complex instrument the use of which is designed to be learned primarily as part of ASW training. The ASWs involved in this research however, were specifically trained for the study, rather than as part of a 'normal' ASW training programme. Training for this research occurred in five stages, using a combination of individual and group training. First, the results of the initial research survey identifying key issues and problems confronting ASWs were presented to the group and discussed in detail. This provided a forum for considering the relevance of CASH. Second, arising out of this, group training took place in the use of CASH over two sessions whereby the ASWs became acquainted in detail both with the main dimensions and detailed categories of CASH, and together with this, the process of assessment which accompanies its use. Third, individual instruction was given on

its use, drawing upon assessments previously undertaken by the ASW, and filling in a schedule in relation to each of these previously undertaken assessments. This served the purpose both of further acquainting them with the schedule and demonstrating its applicability to practice. The fourth stage was a 'pilot' period, lasting three months, when the ASWs used CASH in actual section assessments. This served two purposes. It demonstrated to the ASWs that it could be used in practice situations (there had previously been some reservations in this respect, particularly in relation to possible crises), and it helped them to become proficient in its use. Accompanying CASH was a brief version of the instructions provided by Sheppard (1990), to which reference could be made if necessary when carrying out the assessment. Advice was available on occasions where ASWs were uncertain about its appropriate use. It was only following this training that the actual research was carried out, over the period of a year, from 1 December 1989 to 30 November 1990.

Five ASWs, based at a community mental health centre (CMHC), agreed to involvement in the project. These were experienced ASWs with at least five years post qualifying experience. This has both advantages and disadvantages. It was advantageous because, as experienced ASWs, they were used to making section assessments, and therefore likely more easily to concentrate additionally on developing their use of CASH. However, they were also used to their own personal ways of undertaking assessments, and CASH required they develop further their ways of making these assessments. However, this process is encapsulated in CASH itself, so the use of it meant they were able to undertake assessments consistent with CASH. The CMHC was at the centre of a medium sized city of 240,000, with an overwhelmingly white population, and received the overwhelming majority of referrals received by ASWs in the area. The availability of psychiatrists at the centre meant that, in the overwhelming majority of cases ASWs were accompanied by psychiatrists. It was open only during working hours, Monday to Friday, so data presented here do not include other times, covered by out-of-hours social workers.

This article is divided by methodology broadly into two. The first part involves a primarily quantitative methodology, based on the results gained from the use of CASH. Tests of statistical significance made use of three non-parametric tests (Siegel, 1956). Where the researcher is interested in determining whether the two samples are from populations which differ in any respect at all that is in location or dispersion or skewness, etc, the chi squared test is appropriate. The chi squared test has limitations. Most notably, where  $n < 20$  or the expected frequency in 20 per cent or more of cells is less than five, the Fisher exact test

should be used. It is used when the scores from two independent random samples fall into one or other of two mutually exclusive classes (a 2x2 contingency table). The test determines whether the two groups differ in the proportion with which they fall into the two classifications. The third test used was the Mann Whitney U test which may be used to test whether two independent groups have been drawn from the same population. If we have samples from two populations A and B, the null hypothesis is that A and B have the same distribution. We may have an alternative (to the null hypothesis) directional hypothesis that A is stochastically larger than B or a further alternative hypothesis that B is stochastically larger than A. A two tailed test involves a prediction of differences which does not state direction. It is appropriate for use where the intention is to test whether two samples represent populations which differ in location (central tendency). In relation to these tests the probability values should always be interpreted in the context of the actual differences between the groups.

The second involves a qualitative methodology, based on interviews with ASWs which followed that reported in detail by Sheppard elsewhere (Sheppard, 1990). All interviews were conducted during the week following the compulsory admission assessment. This meant, as the earliest day for the section assessment was Monday and the latest day for the interview was Friday of the following week, the longest gap between section assessment and interview was 11 days. There was, as a result, no problem of recall. The ASWs were always interviewed at their place of work. The degree of training involved was extensive, and there was no problem motivating the ASWs for involvement in the interviews.

The ASWs were asked a number of questions directly related to their conduct, and perceptions, of the section assessment. Those relevant to this study were:

- What were the social circumstances which led to referral?
- What were the problems of health or safety to the patient? or (for the protection of others) who needed protecting and from what did they need protecting?
- Did the schedule help in any respect your understanding and assessment of the situation? if so, how? and
- How long did it take to fill in?

These questions were designed to provide further information relevant to our assessment of CASH. One central issue was the degree of *clarity* displayed by the ASWs in relation to their assessments, and in particular their reasons for admission. By asking them these questions it was pos-

sible subsequently to analyse their answers for the degree of precision with which they identified the dangers and consequences of *failing* to admit. This is of some importance, since it was evident in Sheppard's (1990) research that a lack of clarity was, at times, associated with admission without clear reasons of why it was taking place and inconsistent decision making. Given the implications of compulsory admission for personal liberty, lack of clarity was of considerable concern. It was important not to 'lead' the ASW in this respect, since this might result in more precise answers, suggesting a spurious clarity where it did not, in fact, exist. Thus, following the initial question (what in detail were the problems of health or safety to the patient? or who needed protecting and from what did they need protecting) the ASW was simply asked if they would amplify the statement. This would allow them to elucidate in more detail the way they saw themselves to be acting. These questions also allowed us to examine further the *consistency* of decision making by the ASWs. It became possible to examine ASWs' descriptions in relation to the rating they gave of seriousness of danger. This allowed us to examine whether ASWs were rating similar situations in similar ways and different situations in different ways.

## RESULTS

Altogether 71 section assessments were undertaken by these ASWs during the study year, of which 66 were considered to suffer mental disorder. The data derived from ASWs use of CASH, except where otherwise stated, focus on those cases with identified mental disorder. This is because, if we hold mental disorder constant we can concentrate on the process of assessment of the health or safety of the patient and protection of others which is the focus for CASH. Two difficulties—of adequately training ASWs in the use of CASH and the rate of referral to ASWs—inevitably limits the number of cases which may be considered in this type of study. In view of this, the number of cases analysed here represent a sizeable sample.

## HAZARDS

Hazards are factors which introduce the possibility of an undesired outcome, and dangers are the feared outcome. Dangers arise, or become more likely in the face of particular hazards. The difference may be illustrated by the following example:

Watch out for the banana skin on the pavement, for you may slip and hurt yourself.

Here the danger is that you may 'slip and hurt yourself' and the hazard is the banana skin. The third significant concept, risk, is the likelihood that you will slip and hurt yourself taking into account the presence of the banana skin.

Table 1 shows the six broad classifications covering twenty-seven hazardous situations identified in CASH. This shows clear distinctions between sectionable and non-sectionable patients. Health hazards (focusing on the patient) and threatening violence (focusing on others) were significantly associated with being sectionable.<sup>1</sup> Indeed, these were the key factors in deciding whether or not a patient was sectionable: they were absent in only four of 70 instances where other broad hazards were identified in sectionable patients compared with 18 (53 per cent) of 34 instances for non-sectionable patients. Contravening social regulations was significantly associated with not being sectionable: individuals were, therefore, often referred where their behaviour challenged social rules (for example withdrawing, shouting, creating a disturbance) but this was often considered insufficient to merit sectioning. Analysis of detailed classification reveals a greater range of hazards in sectionable patients, averaging 5.1 compared with 2.95 for non-sectionable patients.

TABLE 1. *Hazards related to outcome: broad areas*

	<i>Sectionable</i>	<i>Non-sectionable</i>	
Health	34 (74)	8 (40)	$p = 0.018$
Failure to provide basic needs	19 (41)	6 (30)	N/S
Threatening violence	35 (76)	5 (25)	$p = 0.0003$
Actual violence	10 (22)	1 (5)	N/S*
Out of control of self and actions	33 (72)	10 (50)	N/S
Contravening social regulations or expectations	23 (50)	16 (80)	$p = 0.044$
Other	5 (11)	2 (10)	N/S*

Figures in brackets are the percentage of each group for which hazards in the relevant broad area were identified. The chi squared test with Yates correction has been used to test for significance except for 'actual violence' and 'other', neither of which is significant, and where Fisher's exact test\* was used.

<sup>1</sup> 'Sectionable' refers to individuals who were either sectioned (under sections 2, 3 or 4) or who would have been sectioned had they not agreed to informal admission. Not sectionable refers to individuals who were not admitted or who were admitted informally, but would not have been sectioned had they refused admission.



## DANGERS

*Mental Health Danger.* (Table 2) Danger is the feared outcome in the face of a particular hazard. CASH divides these into four: health (mental or physical) or safety of the patient, and protection of others, consistent with the Act. Mental health was an important aspect of 'health or safety', identified in 63 per cent of sectionable and 30 per cent of non-sectionable patients, although in sectionable patients mental health threat had to be quite or very severe. In 32 of these 35 cases, whether sectionable or not, the mental health threat was psychotic. However, mental health threat was rarely considered significant enough on its own to justify compulsory admission: on only two occasions were individuals sectioned on mental health grounds alone.<sup>2</sup> This provides evidence of a balance of consideration of mental disorder with health or safety of the patient or protection of others criteria characteristic of the Social Risk orientation which CASH was intended to encourage.

TABLE 2. *Dangers—Severity related to outcome*

	<i>Mental health</i>		<i>Physical health</i>		<i>Safety</i>		<i>Protection of others</i>	
	Sect.	Not Sect.	Sect.	Not Sect.	Sect.	Not Sect.	Sect.	Not Sect.
Mild	—	—	2	3	1	5	1	3
Mild to moderate	—	2	3	—	1	5	4	3
Moderate	—	4	5	—	2	5	8	2
Quite severe	23	—	7	—	12	—	11	1
Very severe	6	—	4	—	16	—	7	—
Total	29	6	21	3	32	15	31	9

Significant, or just below significant results were obtained using the Mann Whitney U Test for:

Mental health: corrected for ties, 2 tailed test —  $p < 0.001$   
 Physical health: corrected for ties, 2 tailed test —  $p = 0.01$   
 Safety: corrected for ties, 2 tailed test —  $p < 0.001$   
 Protection of others: corrected for ties, 2 tailed test —  $p = 0.002$

<sup>2</sup> On all other occasions it was associated with one or more other danger. Dangers were divided by type, based on distinction in the Act. Thus there were health dangers (mental or physical), safety dangers, and dangers involving protection of others. Multiple dangers were considered to occur where more than one of these danger areas were identified in a single case, at moderate or above severity. Table 5 shows a 'cut off' point of moderate danger distinguishing the overwhelming majority of sectionable from non-sectionable patients.

*Physical Ill Health Danger.* CASH distinguishes between both sectionable and non-sectionable patients (Table 2) and between different levels of severity associated with particular dangers. All five cases where the physical health threat was less than moderate were multiple danger cases. The type of physical health threat was classified by Sheppard (1990) as a means, broadly, for informing ASWs, as laypersons in relation to physical illness, in the assessment of severity of danger. Thus, life threatening illness was considered generally more severe than that requiring specialist hospital treatment, in turn more severe than that requiring GP treatment or which was transient (see Sheppard (1990) for an extended discussion). Although intended as a rough rather than precise guide, since there could clearly be overlaps, there was a clear relationship between type and rating of severity of physical health threat. This can be expressed by attaching a score, ranging from one to five, to rating of severity.<sup>3</sup> Life threatening illness averaged 4.75, specialist hospital treatment averaged 3.15, requiring GP treatment and transient illness averaged 1.66. This broadly consistent relationship between nature and rating of danger is consistent with the original aims of CASH.

*Safety of the Patient.* A threat to the safety of the patient was identified in the majority of both groups, with ratings (apart from minor overlaps) of greater severity associated with sectionable patients (Table 2).<sup>4</sup> The sensitivity of rating to the type of danger is again indicated if we give a numerical rating to the severity of danger and relate it to type of danger. The critical safety threats were death, injury and rape, and other threats were of marginal importance.<sup>5</sup> There was a greater range of safety dangers amongst sectionable than non-sectionable patients, averaging 2.38 for the former and 1.6 for the latter.

*Protection of Others.* Despite some overlap, explained in the same way as overlaps in safety of the patient dangers, sectionable patients were rated as more dangerous than non-sectionable patients. This contrast is most evident in relation to the more dangerous extreme, where in 21

<sup>3</sup> Very severe, 5; quite severe, 4; moderate, 3; mild to moderate, 2; mild, 1.

<sup>4</sup> Both cases rated less than moderate were multiple danger cases. Where non-sectionable cases were rated as moderate they were not multiple danger cases and ratings of overall risk (see below) placed them below moderate seriousness. This indicates that a rating of moderate severity in one area was possible without, overall, the seriousness of danger and level of risk being sufficiently great for individuals to be sectionable.

<sup>5</sup> Average ratings were: death, 4.87; rape, 4.5; injury, 4.33. Where death, injury or rape are excluded, the ratings of severity in other areas drop to practically the minimum possible: loss of family, spouse, child and material goods were rated as one, loss of social relations as 1.67 and prosecution as 1.2.

cases of threats of physical harm or injury to others and six of death, only one was evident in non-sectionable patients. The sensitivity of rating to type of danger is again gauged by attaching a numerical value to severity, as previously shown, with death, physical harm and injury rated as far more severe than all other types of danger.<sup>6</sup> Together, these data confirm the significance of more serious dangers to others in ASWs' assessments.

*Wide versus narrow interpretations of the law.* Sheppard (1990) distinguishes between wide and narrow interpretations of the law. This is most obvious in relation to protection of others, where a narrow interpretation involves only acts of violence (Anderson-Ford and Halsey, 1984), a wide interpretation goes as far as to include irritation and nuisance suffered by neighbours (Hoggett, 1984) and a third position lies between the two, protection involving emotional strain as well as physical harm (Jones, 1988). Sheppard (1990) expressed the hope that the *range* of interpretations (narrow to wide) would become narrower with the use of CASH. These results suggest a *narrow* rather than *wide* interpretation of the law by ASWs, with a concentration on more serious circumstances rather than those which cause social irritation. Hazards contravening social regulations, such as disturbance, lawbreaking or failure adequately to carry out a significant role area (for example child care) were significantly associated with individuals *not* being sectionable (although such hazards did not preclude sectioning). Amongst dangers the critical threats to safety of the patient were death, injury and rape, and for the protection of others, death, physical harm or injury.

#### RISK

Risk refers to the increased likelihood of a loss outcome (in our terms danger) in the face of particular hazards. CASH identifies two areas which may contribute to or reduce risk levels: the behaviour of the patient—involving five alternatives (Sheppard, 1990) and availability and adequacy of support. In 44 of the 46 sectionable cases *patients' behaviour* contributed to the increased probability of danger compared with 7 of the 20 non-sectionable patients. Patients' behaviour broadly contributed in three ways; by commission (that is by doing something, increasing the danger, 19 cases), by omission (by not doing something, increasing the danger, 13 cases) and by presenting a barrier preventing

<sup>6</sup> Average scores: death, 5.0; physical harm/injury, 4.72; physical illness and mental illness, 4.0. If we exclude cases where death, injury and physical/mental health are involved, ratings drop dramatically, averaging 2.0 for all other dangers.

others from helping (12 cases).<sup>7</sup> CASH, therefore, enabled ASWs to indicate clearly the contribution of the patient to risk.

A second element of risk relates to available *supports*. We may be seriously concerned for an elderly demented man living on his own (he may wander off into the traffic, he may leave fires or chip pans on), we may be less concerned—the risk may be less—where adequate supervision is available. CASH divides support in eighteen categories within two domains, instrumental and emotional support. Table 3 shows the total number of support areas identified in relation to sectionable and non-sectionable patients. These are divided into three: supports required, available and adequate,<sup>8</sup> which are together defined as support needs. On average, more support needs were identified for sec-

TABLE 3. *Support related to outcome: total number of support areas identified*

	<i>Required</i>	<i>Available</i>	<i>Adequate</i>	<i>Total</i>	<i>Support per person</i>
<i>Sectionable</i>					
Instrumental	75 (54)	55 (40)	8 (6)	138	3.0
Emotional	17 (52)	12 (36)	4 (12)	33	0.7
<i>Non-Sectionable</i>					
Instrumental	15 (32)	9 (19)	23 (49)	47	2.35
Emotional	4 (36)	1 (9)	6 (55)	11	0.55
<i>Total</i>					
Sectionable	92 (54)	67 (39)	12 (7)	171	3.7
Non-Sectionable	19 (33)	10 (17)	29 (50)	58	2.9

Figures in brackets represent the percentage of total in each row. The number of support areas identified may at times exceed the number of patients assessed. This is because an individual may have more than one support need identified.

<sup>7</sup> Examples of these types are;

*Commission*—'bolting across the road' without any care for traffic, deliberately hoarding tablets, intent on suicide, trying to make (highly explosive) rocket fuel.

*Omission*—entirely involved individuals who had not taken necessary medication or failed to eat.

*Those presenting barriers*—one person's offensive behaviour had alienated others who would no longer help, another locked her home help in the cupboard, who now refused necessary support.

<sup>8</sup> Supports are defined as 'required' where such support was required but support was neither available (from anyone else) nor adequate. Supports are defined as 'available' where support was required and was available, but the support was not considered adequate. Support was considered 'adequate' where it was required, available and adequate.

tionable than non-sectionable patients,<sup>9</sup> and, for sectionable patients, far more support needs identified were required, or required and available (but not adequate) than support needs that were adequate. Furthermore, the most prominent support needs identified in sectionable patients—supervision of taking medication, monitoring behaviour and nursing/health support were also overwhelmingly not adequately provided. These particular support needs are entirely consistent with hospitalization: behaviour may be monitored, nursing provided and medication given most effectively in the closed medical environment of the hospital.

Table 4 shows the average risk score for each broad area by type of support. Each broad area contained a number of individual categories. The data presented here are based on a number of cases where, in each broad support area, one or more category (of required, available and adequate support) was identified by the ASW.<sup>10</sup> The score for each support area was based on the rating of level of risk where each of the above supports figured.<sup>11</sup> Table 4 is quite striking. Interestingly, risk scores indicate that *availability* of support had little impact: it was when

TABLE 4. *Broad areas of support: average risk score related to support need*

	<i>Required</i>	<i>Available</i>	<i>Adequate</i>	<i>Total</i>
<i>Instrumental</i>				
Health	3.79	3.92	2.50	3.71
Personal-instrumental	4.17	3.81	2.22	3.70
Task support	3.83	4.00	2.85	3.36
<i>Emotional</i>				
Personal-emotional	3.92	3.62	2.67	3.55
Emotional support to others	3.50	4.00	2.75	3.43

<sup>9</sup> The difference between instrumental and emotional support in number of support areas identified should be understood in relation to a smaller number of categories classifying emotional support.

<sup>10</sup> *Health support* included: nursing/health supervision, supervising taking medication, personal hygiene supervision;

*Task support* included: cooking, home management/cleaning/shopping, physical supervision of children, physical supervision of other dependents, supervision of finances;

*Personal instrumental* support included: personal physical aid, supervision of eating, accommodation, monitoring behaviour;

*Personal emotional* support included: emotional support/ventilation, psychodynamic support.

*Emotional support to others* included: emotional support for the patient's distressed relatives, providing children's emotional/developmental needs.

<sup>11</sup> The scores were as follows: low risk, one; fairly low, two; moderate, three; fairly high, four; high, five. The score in each support area represents the average for all the cases where that support was identified.

it was considered *adequate* that risk levels reduced (cf Henderson, 1984; Henderson *et al.*, 1981). It was not sufficient for someone to *offer* help: only adequacy reduced risk. This has major implications for social work: if in potential crisis situations, support has been developed, this may reduce the likelihood of compulsory admission. This provides further support for Sheppard's (1990) emphasis on the relevance of preventive work for section assessment.

#### EVIDENCE

The accumulation and evaluation of evidence is of obvious importance when conducting assessments. Sheppard (1990) identified two key dimensions, *comprehensiveness* and *reliability*, in the accumulation of evidence. Comprehensiveness involves obtaining information, as far as possible from all relevant individuals, making the assessment as thorough as possible. Reliability involves the critical analysis of evidence and the collection of sufficient information, and to be as confident as practicable that the information gleaned is clear and accurate. CASH tackles this by asking the ASW to identify whether the main relevant individuals were interviewed as part of the assessment process, and where some were not interviewed, why they were not.

These data are analysed in terms of the whole group, rather than only those with a mental illness. In 64 cases some relevant others (apart from the patient and participating professionals) were interviewed. With the exception of two of the other cases lack of contact was understandable, and, importantly in the assessment of CASH itself, in all but one case, the ASW provided some justification for limited contact with others, the question having forced them to consider this issue. The most frequent contacts were made with spouses, mothers, daughters and neighbours. In 27 cases, however (38 per cent), the ASW did not interview all relevant individuals. The reason for this may be grouped into four from ASW accounts: those not available or at work (15 cases), those living away (4 cases), relatives not known (2 cases) and six cases involving a variety of individual reasons. In only two cases were the reasons for failing to interview questionable.<sup>12</sup>

<sup>12</sup> *Case involving lack of contact:* in one case the ASW wrote 'mother not interviewed, not available', but subsequently commented that, in retrospect, this was possibly wrong (the woman had overdosed and the doctor said the mother could not cope). In another case the ASW made no comment. The latter case involved no justification for not interviewing. *Cases where reasons for not interviewing were questionable:* In one case a father was not interviewed, although the patient was 'making definite threats against his dad' and had been thrown out by his father two weeks previously following a fight. In another case the father of a woman expressing 'pathological hate' against him and making threats was not contacted. In both cases the relationship between these people and the patient were clear aspects of the danger being assessed.

CASH allowed ASWs clearly to indicate those who were interviewed, those who were not and *reasons* why some were not interviewed. In this respect it helped highlight the importance of comprehensive assessment, helped ASWs justify their actions and provide reassurance that their assessment had been as comprehensive as possible. Inadequate explanations of failure to contact by these ASWs, trained in its use, were rare.

#### OVERALL RISK

Table 5 shows a combined danger and risk rating (overall risk) related to outcome. Three ratings are significant in the final element of assessment: overall danger, assessed after individual danger areas have first been assessed, risk, and overall risk, comprising the combination of risk and danger. Sheppard (1990) argues, on theoretical grounds, that danger has logical priority over risk in the assessment of overall risk: there may be considerable concern about a moderate risk of a serious danger, such as death or serious injury, but far less concern over a high risk of a mild danger (such as a cold). Table 5 shows that this is the case in practice. Outcome, as would be expected if the schedule adequately expressed practice situations, was closely related to the seriousness of danger and level of risk.

Sheppard (1990) introduced the concept of the 'threshold of risk' to identify the threshold distinguishing between those eligible for section and those not eligible. He suggested the threshold would not involve a clean distinction between these two groups, since there could never be perfect consistency between ASWs in different situations, but there would be a 'grey' area, where the decision might go one way or another.

TABLE 5. Overall risk related to outcome

	Sectionable	Non-Sectionable
1. Mild/mild to moderate danger	–	12
2. Moderate danger/low–fairly low risk	–	6
3. Moderate danger/moderate–high risk	3	1
4. Quite or very serious danger/ low–fairly low risk		
5. Quite or very serious danger/moderate to serious risk	43	1

Comparison of categories one and two with categories three, four and five:  
 $\chi^2$  52.48  $p < 0.0001$ .

In the interests of justice, however, we should strive to keep inconsistency to a minimum, and this grey area should involve as few cases as possible. He presented a diagram with danger on one axis and risk on the other, and the threshold was presented similarly to an indifference curve, whose width would be as narrow as possible. Figure 1 shows the threshold of risk is quite different from Sheppard's theoretical formulation. Instead of an indifference curve, the data reveals a 45 degree X shape. The distinction, in other words, is far clearer than Sheppard expected. This appears, in part because those rated as less than moderate danger were also rated moderate or less risk, while those rated above moderate danger were rated above moderate risk.<sup>13</sup>

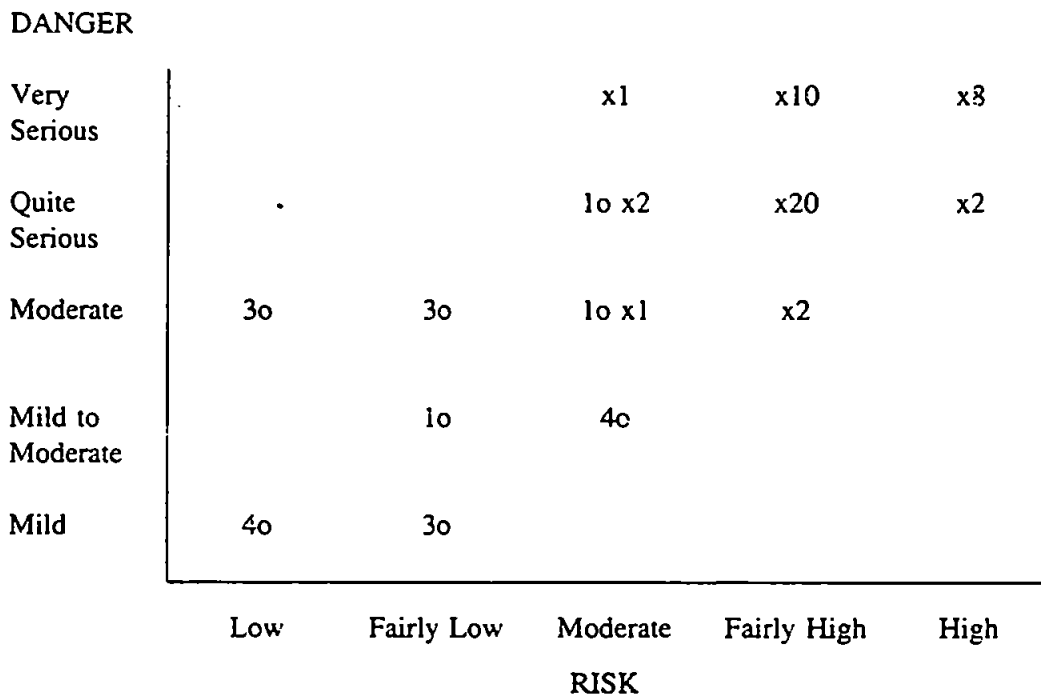


FIGURE 1. Overall rating of risk

c = non sectionable patients  
 x = sectionable patients

Number of patients at each rating level is indicated by the number attached to each symbol. For non-sectionable patients the number is to the left of the symbol. For sectionable patients it is to the right.

<sup>13</sup> In two cases those with relatively high ratings of danger and risk individuals were not sectioned. In one case the ASW actually wanted to section but the doctor refused. In the other the ASW argued that, while he was prepared to concede a mental illness was probably present, although they were unable to give a precise diagnosis, he did not know enough about the patient's mental health, given environmental factors.



## RATING OVERALL DANGER

The following results are based on analysis of all seventy-one cases involved in the study. Its major concerns are with some overall issues: the extent to which clarity in risk assessment is associated with the use of CASH, the extent to which rating involves real differences in severity of danger and induces consistency between ASWs in their assessment and the extent to which ASWs felt CASH made a positive contribution to their assessment. The apparent consistency of quantitative data may simply reflect suppression of real differences in criteria used to rate cases. One ASW may rate a situation moderate which another rated quite severe. However, qualitative data, provided by ASWs' descriptions of patients' circumstances, can examine further the consistency implied by quantitative rating.

Sheppard's (1990) research expressed concern over consistency, and hence the problem of, as far as possible, treating like as like, according to the principles of justice (Miller, 1976). CASH, Sheppard (1990) suggested, may encourage greater consistency.

*Mild danger.* Ratings of mild danger were consistently associated with mild social disturbance and chaotic or disorganized social life. One par-aphrenic woman had discharged herself, others expressing fears that she would deteriorate mentally and in social functioning.

In the event she was lucid, rational, the place was clean, she had food in the home, we found she'd made arrangements to turn the electricity. She still had to arrange her social security though.

Another was withdrawn, lived in a 'grotty bedsit' and had 'no direction in life', possibly becoming depressed.

It was about self care . . . his self care was very limited—he was living out of a fish shop for example—you wondered if he was eating properly. The room was bare. . . . His personal hygiene was adequate. He was really nothing like the level required for a section.

*Mild to moderate danger.* Mild to moderate ratings were marked by a greater emphasis on the effect of patients on others outside the family. Each of these cases, furthermore, were previously well known to the psychiatric services. Finally there was a greater number of identified dangers. It may be that multiple dangers tipped the balance between mild and mild to moderate ratings.

One man, previously sectioned for schizophrenia, was exhibiting, the ASW thought, 'extreme religiosity'. He seemed 'very chaotic' and had

come to the attention of the police because of a non violent dispute outside a neighbour's home:

He was trying to get into the house to preach to somebody . . . and this led to an argument . . . he had a religious bent . . . but I thought those on their own did not justify admission . . . he was not totally out of touch with reality.

Another woman 'was becoming more isolated, she was periodically shouting at people, there was an element of self neglect'. However, although there was some concern 'future assessment was needed' as things were not too serious yet.

*Moderate danger.* The greater severity of problems in the moderate group is evident in three respects: first a greater number and variety of dangers identified, second in practically all cases the mental disorder was a central feature, and third issues relating to self care, disruption of social relations and pestering neighbours were both associated with mental illness and more serious than with milder dangers. Issues of injury, death and serious ill health did not, however, feature. This was clearly expressed in one example. Concern was expressed about one woman's 'increasingly deluded and hallucinatory state'. The ASW felt

She wasn't looking after herself. She hadn't bathed in ten weeks because she felt there were people upstairs so she was in a very dirty and dishevelled state. She had been arguing with her neighbours and had broken a few windows in her house. Her level of hygiene had deteriorated to a great degree and that could have led to health problems. She was hearing voices and was insistent that I hear voices too—she told me to press my head against her ear so we could both listen.

*Quite serious danger* was marked, in general, first, by an increased number of identified dangers, and second, these dangers tended to involve more serious physical health or injury either to the patient or others. Together with this, these cases were generally marked by multiple dangers, many of which were rated as serious. Concerns ranged from possible injury, serious physical health danger and possible sexual assault. For example, one manic woman said 'she wanted to prostitute' and was making sexual advances to others:

It was the sexual bit—the whole way she was presenting . . . she was also aggressive—she could have been hurt or have hurt others. She physically hit the GP. She was also not in a position to care for her child.

In another case of a man deteriorating following his mother's death:

He had been drinking a lot and not eating properly. His personal hygiene was appalling. Physically he's going downhill—he's lost a lot of weight—he has

abdominal pain. I would query myself a possible ulcer. There was blood on the loc.

*Very serious danger.* Very serious danger was, with one exception, marked by two associated factors: a serious concern over possible death of the patient or others, and a serious mental health condition. The descriptions by the ASWs show just how fraught these situations were. One woman

had overdosed and had been up at [general hospital]. She had made several suicide attempts on the ward and at home. She had tried to burn down the nursing home [of her father]—she was keen to take everyone with her. Her brother had recently died and she had broken up with her boyfriend recently. . . . In the interview she stated quite categorically that she wanted to kill herself. . . . I think she had a pathological hatred towards her father. I think others as well—the psychopathic bit . . . the fact that she was attempting to burn down a residential home put people's lives at risk.

Other cases showed this combination of severe mental disorder, fraught circumstances and threat of death. One manic woman, with 'no insight' had 'a can of petrol in the middle of an unlit fire which was clearly ready to light', while a woman, psychotically depressed, had 'actively considered throwing herself under a train'.

Two themes emerge from an examination of the relationship between situations confronted and rating of those situations: that different ratings distinguished between different kinds of situations with differing levels of seriousness, and there was a high degree of consistency between different ASWs. There were only five exceptions: in two cases an ASW rated the threat of death as quite rather than very serious, while another case was rated quite serious when possessing characteristics more consistent with a 'moderate' rating—involving disruption of social relations and self-care problems. Finally, two cases were rated as very serious when injury rather than death was the feared outcome. It is interesting, however, that none of these variations differed by more than one rating level from other cases with similar characteristics.

#### DANGERS AND RISKS: CONCEPTUAL ACCURACY

*Dangers clearly indicated.* The ASWs making the assessments on the whole showed a high degree of conceptual clarity. This was important, not simply as an indication of intellectual elegance, but because of its implications for practice. Dangers, risks and hazards, as we have seen, are conceptually separate, and each require consideration. It is, however, *feared outcome* (if they are not sectioned) which is most significant.

ant. It is the danger that provides the primary justification for compulsory admission (rather than remaining in the community).

The overwhelming majority of cases where individuals were sectioned involved clear identification of the danger. One woman was severely depressed and suffering delusions, had isolated herself socially, and had stopped eating.

Another bit of the psychosis was that she was responsible for the imminent destruction of the world. . . . She was awaiting her punishment and didn't feel she could face this. We were concerned that she might choose to self harm. . . . She certainly didn't care if she died through lack of eating. She'd considered throwing herself under a train at Totnes.

The danger—death—was clearly identified in this account. In other cases less serious dangers were identified such as injury. One manic woman, for example, who was 'inviting problems' in the street 'could have possibly got assaulted, and might have got injured if she wasn't thinking straight', while another manic man presented both a mental and physical health danger. 'I felt', said the ASW, 'his sleeplessness and restlessness were likely to cause him health problems and he could suffer exhaustion'.

*Lack of Clarity.* Sheppard (1990) classified accounts other than those clearly identifying danger into two: where, without identifying danger (a) the hazard was identified and the danger obvious and (b) the hazard was indicated, but the danger unclear. In the former case, the accounts, although not identifying danger with clarity, did provide some justification for admission. The latter, however, was of serious concern, because it was unclear that the danger was sufficiently great, or imminent, to justify admission. This approach contained clear elements of the 'presumption of risk', which CASH intended to avoid—a lack of clarity in assessment, and pessimism in the face of mental disorder.

ASWs failed to give a clear account of danger on only nine occasions. However, most cases involved multiple dangers, and, given that many cases involved multiple dangers, in *no* cases did ASWs fail to identify *any* danger with clarity. These figures are dramatically below those reported by Sheppard (1990) in the research leading to the development of CASH, where, of 90 cases, the hazard was indicated and danger obvious on 30 occasions and danger was unclear on 20 occasions. In three cases, although one of the dangers was not clearly stated, it was obvious from the hazard: for example, there was concern over the manic woman, who lacked insight and wanted to drive to Oxford: 'I don't think she could have given due care and attention to her driving.

Because of her manic state she would have taken undue risks'. Although not stated, the danger, of injury or death, was obvious.

In six cases one of the dangers was unclear. For example, an elderly woman, believing that people she saw were imposters, was highly reliant on her home help, whom she locked in the scullery.

The home help felt at risk and therefore wouldn't revisit. Therefore the woman had difficulty in her shopping and cashing her giro cheque for instance.

The precise danger is unclear. What exactly would the consequence have been? Lack of food? Or would she have found some way of obtaining food? Would this have led to physical illness? Death? How imminent would be the danger?

#### IMPACT OF THE USE OF CASH

The ASWs were asked if the use of CASH helped, in any respect, their understanding and assessment of the situation. In most cases—50 out of 71—the ASWs felt it was helpful. Where ASWs considered it made no difference, it was because the situations made the decision about admission clearcut. Even where ASWs felt it made no difference, on a few occasions they noted that CASH became more useful where decisions were less obvious or there were unclear areas. CASH generally took ten minutes to complete. There was some variation however, reflecting the complexity of the case. In these circumstances ASWs displayed active use of CASH as an aspect of assessment, as, for example, with the ASW who decided to think further about the case overnight after making use of CASH.

ASWs considered CASH to have been helpful in a wide variety of ways, and there is room only to give examples of their comments.<sup>14</sup> One of the ASWs indicating that CASH helped them transcend a medical to more social understanding said:

From a purely medical point of view there were grounds for a recommendation . . . but we had different standpoints and it helped me think the whole thing through. I got more information on his social situation and on that basis the

<sup>14</sup> Analysis of ASWs' comments allowed the following classifications to emerge of the ways they considered CASH to have been helpful: (a) clarifying the whole process of assessment, (b) clarifying lack of problems, (c) helping them be more specific in identification of hazards, dangers and risks, (d) giving them a greater sense of confidence in confirming decisions they would have made anyway (e) forcing them to think through the relevant issues (f) helping increase the breadth of assessment (g) helping them transcend a medical with more social understanding (h) helping them keep the civil rights issues to the forefront in assessment (i) the help given by specific aspects of the schedule, such as alerting them to the number and range of factors, degree of urgency and the significance of elderly frailty.

doctor agreed with my assessment. . . . Although there was some risk I thought it was worth erring on the side of leaving him.

Another commented on the issue of civil rights: it 'was a fairly difficult decision. She felt her civil rights were being violated . . . trying to balance that with the decision of what the dangers were was difficult . . . it was useful to have something as clear as the form to help out'. Another, commenting on the impact of support on risk said 'the bit on social support . . . made me consider what resources were needed and . . . available', while a further ASW noted it helped identify the number of particular factors involved 'in that it concentrated largely on areas of loss—of family and so on—and the possibility of violence'.

## DISCUSSION

CASH manages to achieve a number of goals which have been set for it. CASH appears highly sensitive to differences between sectionable and not sectionable individuals. This is most obvious in ratings of overall risk, where the 45 degree X shape indicated very little overlap in overall risk rating between sectionable and non-sectionable patients. This suggests that CASH reduces unclear areas where inconsistencies between different ASWs may arise, because of the systematic procedure, clarity of assessment and greater precision occurring in rating dangers and risks. This is also evident in relation to specific danger areas, defined by the Act, such as physical health, safety and protection of others. Assessing and rating these dangers was part of the process which led to a rating of overall risk. Clear differences existed between ratings of those sectionable and not-sectionable in each danger area, with only a small amount of (explainable) overlap.

Sheppard (1990) suggested that CASH would be associated with more *consistent assessments* between different social workers. Qualitative data, provided by ASWs' description of patients' circumstances confirm the consistency implied by quantitative rating. The possibility of consistency is bound to be complicated by the interpretation of the law, with the possibility of narrower or wider interpretations, mentioned earlier. In fact the ASWs appeared fairly consistent in their interpretation, adopting an intermediate position which included emotional distress to others as well as injury or death.

While consistency was an aim of CASH the clarity of the differences in characteristics between different levels of danger was not anticipated. In training, the ASWs were not told which factors would be expected to characterize different levels of seriousness of danger: this was left to their judgement. Yet an exciting outcome of research is the identifica-

tion of characteristics of different levels of danger which make considerable intuitive sense, and which suggests that further work may be undertaken to extend the description of characteristics appropriate to each level of danger, offering a real hope, if incorporated into training, of further encouraging consistency between different ASWs.

There is an *internal validity* in ratings made by ASWs also. There is a clear relationship between the *type* of danger feared and the rating of its severity. This is obvious, in particular in the areas of physical health, safety and protection of others. With physical health, the classification discriminates between different types of health danger in a way appropriate for assessment of risk by non-medical personnel. In other areas rating distinguished clearly between more or less severe dangers: death, injury and sexual assault, for example, contrasts greatly in rating severity of danger with other areas.

*Clarity* is also evident with Level of Risk. CASH made it possible to identify the ways in which the patient contributed themselves to the risk, the types of support necessary to reduce the risk, the significance of the adequacy of support to risk reduction and to relate these to a rating of risk. It also enabled the ASWs to be clear in relation to evidence: about whom s/he had contacted, whether or not relevant individuals had been interviewed, and why some had not. This contributed both to comprehensiveness and reliability in assessment.

The qualitative analysis of ASWs' accounts show that clarity was also evident in the ways they thought about their assessments and that this was considerably greater than evident in previous research where CASH was not available (Sheppard, 1990): the majority of cases involved multiple dangers, and there was no case where at least one danger was not clearly identified. Clear identification of danger is of great importance because of the significance of individual civil rights an individual's liberty is effectively at stake, and the ASW should be clear about *exactly what* they fear to be the consequence of failing to admit the patient. A lack of clarity may mean that an individual is admitted where such admission is not justified by their circumstances. A further point is that clarity may be expected to improve consistency of assessment between ASW—evidence of which we have already noted.

While recognizing that clarity was greater than in previous research, some points should be noted. We cannot be sure that this clarity was the result solely of the use of CASH—it may be primarily because of the training that occurred, with its emphasis on clarity and conceptual differentiation of the critical elements of the analysis of risk. If so, it is the *training in the use of CASH* which is significant. However, such separation between the impact of training and use may be hard to identify and in the last analysis be somewhat academic—the outcome,

in terms of greater clarity, is the same. Furthermore, continuous use of CASH would itself be expected to reinforce the conceptual ideas underlying CASH and hence help retain a more sophisticated and theoretically informed compulsory admission assessment. Finally, the ASWs themselves were, on the whole, positive about the use of CASH in *practice* situations.

CASH was clearly *practical to use*. In most cases where matters were fairly clear it took only ten minutes to fill in. These were, of course, ASWs who were thoroughly trained in its use. This is very important, since ASWs' reactions to CASH are likely to vary according to their degree of familiarity with it. There are two relevant processes. First, there is the mental effort required to locate relevant factors and know the meaning of different areas of CASH (such as the relationship between the nature of the danger and related vulnerability factors). Where ASWs are not familiar with CASH they are likely to consider that the effort of using it detracts from the important business of the actual assessment. This may induce a sense of frustration—that CASH *gets in the way* of assessment. Second, however, adequate training and familiarity, which is required in the use of CASH, means that ASWs are not distracted by CASH itself from the business of assessment. In that case it becomes *part of the assessment process*, and helps the ASW to consider their assessment more carefully and systematically. There is a danger, therefore, that inadequate training would lead to frustration with it, and for some ASWs unnecessarily to give up on it. However, the absolute centrality of risk assessment in compulsory admission assessment indicates that adequate training should be provided. The existence of ASW training allows sufficient time to be made available as part of that training to allow ASWs to become adequately familiar with CASH.

CASH provides a basis for *accountability* not otherwise available, particularly if used in relation to all section assessments. Bean (1980) comments on the essentially private nature of section assessments: undertaken by professionals, away from public gaze and separate from the courts, despite serious implications for personal liberty. CASH can serve two purposes in relation to accountability. It can, cumulatively, provide a clear picture of the nature and process of assessments, and reasons for outcome in any particular social services authority. This would both aid public accountability and allow departments to monitor ASW activities with a view to training needs.

Finally, we may consider ASWs' comments. In most cases ASWs *found it helpful*, and the variety of reasons given, specific to particular cases, confirms its flexibility and applicability to the variable circumstances confronted in practice. Even ASWs who said it had added noth-



ing to their assessment of particular cases frequently commented that its greatest use was in cases where the outcome was not straightforward.

APPENDIX: THE COMPULSORY ADMISSIONS ASSESSMENT  
SCHEDULE  
(CASH)

The Compulsory Admissions Assessment Schedule (CASH) was developed by a combination of theoretical concepts—derived largely from Risk Analysis, but also involving theoretical considerations of social support, threat and loss and empirical analysis of practice, guided by issues derived from the theoretical analysis of the role of the Approved Social Worker and Risk Analysis. CASH is designed to help the ASW think through the issues of assessment precisely and with as much clarity as possible, and to force them to justify their decisions, both through detailed ratings of the various aspects of assessment of overall risk, and by presenting evidence where necessary in support of their decisions. It is intended to provide ASWs with a distinctive knowledge base which encapsulates what Sheppard (1990) has defined as a 'Social Risk' orientation. This basically involves giving the assessment of the health or safety of the patient and protection of others criteria equal status to mental disorder criteria; emphasizing the need for these criteria to be examined individually and in their own right; affirming the need for precise identification of dangers hazards and risks; and the need to avoid admission unless there is clear evidence that it is needed.

CASH is a semi-structured instrument designed to be used by ASWs in the process of assessment for compulsory admission. It is a detailed instrument, which requires training in its use, which is more easily achieved through ASW training courses. CASH is broadly divided into six areas, designed to examine overall risk, defined by the Act, to the health or safety of the patient or the protection of others: hazards, four types of danger—mental and physical ill health, safety of the patient and protection of others—and level of risk. Each contain detailed classifications, as well as elements assessing factors accentuating the danger or increasing or reducing the level of risk. Detailed instructions on the interpretation and use of CASH are provided elsewhere (Sheppard, 1990).

*Hazards*, which are assessed first on the schedule, gain their significance from their association with danger. Danger is the possible loss outcome which occurs in the face of a particular hazard, e.g. someone may slip and break their leg (danger) if they step on a banana peel (hazard). Hazards are divided into six categories. Health hazards are self-explanatory. Failure to provide basic needs refers to those basic biological requirements to sustain adequate life. Threatening violence involves hazards where by action or verbal communication possible future violence is indicated. 'Actual violence' involves violence already occurring when the ASW makes their assessment. 'Out of control of self or actions' refers to a state where, without threatening or being violent, the patient is not aware of the possible deleterious consequences of what they are doing.

'Contravention of social regulations or expectations' involves, for example, breaking the law or inability to carry out a significant role area such as neglect of the child rearing role.

*Danger* is the possible loss outcome arising in the face of a hazard and is conceptualized in terms of threat, a 'forward looking' concept linking hazards to dangers (a hazard creates a threat of a danger). Dangers are divided into four, reflecting specifically the criteria of the 'health or safety of the patient or the protection of other persons': mental health, physical health, safety of the patient and protection of others. Each of these dangers are divided into two: the danger itself and vulnerability factors which have an impact on the severity of the danger. *Mental Health Danger* is classified according to categories in three broad areas, neurotic, psychotic and organic psychotic. A rating of the severity of danger and significance of supplementary factors is made after the danger is identified. These are on scales of 0 (not present) to five (very severe or very significant). Physical health danger is divided into two: the danger itself and vulnerability factors likely to affect the severity of that danger. *Physical health threats* are classified from no physical illness to life threatening, in a form appropriate for laypersons (in relation to physical ill health). Ratings are made of danger and vulnerability in the same way as mental health threat. *Safety threat* is considered in terms of the concept of loss. This is divided broadly into three domains: physics (e.g. injury), loss of social relations and material loss. These are rated in relation to associated vulnerabilities in the same way as physical and mental health threat. Protection of other persons involves a wide variety of factors from which others might need protecting, varying from death, through emotional trauma to intrusive behaviour. Vulnerability is assessed in relation to particular threats, and the ASW is required to identify the focus for the danger i.e. who it is that requires protecting (e.g. spouse, children, generalized others). Rating are subsequently made in the same way as mental health. At this point the ASW is required to make an initial evaluation of the *seriousness of the danger*. This is an overall rating of danger made in the light of the dangers identified, the severity of the dangers and significance of vulnerabilities and the hazards predisposing towards the dangers. Seriousness of danger is rated on a scale of six points from not present (0) to very serious (5).

*Risk* is next evaluated. Risk is the concept which links hazards to dangers. Risk is closely associated with the probability that particular dangers will occur. Thus the danger of breaking one's leg is greater if a banana peel (hazard) is on the pavement than if it is not there (all other things remaining the same). Hence the presence of the banana peel increases the risk of a broken leg. The assessment of risk, therefore, should be a rational analysis based on the properties of interacting elements. Risk is examined in terms of factors which make the danger more or less likely to occur in the face of a particular hazard. These are divided into two: the extent to which the *behaviour of the patient* is contributing to the likelihood of the danger occurring, involving five alternatives (see note 11) and *social supports* which may reduce the likelihood of the danger occurring. These are classified broadly into instrumental and psychological support. Each support area is examined in terms of whether it is required to keep the patient in the community, whether it is available, and if available whether

it is adequate. The ASW is required to identify who is available to provide support, and if available why they are considered adequate.

The final area is the *evaluation of evidence*. In many respects this has already been considered, insofar as ASWs are required to identify precisely and rate hazards, dangers and risks. Evidence is considered in terms of its comprehensiveness and reliability. Comprehensiveness is sought by asking whether the main relevant individuals were interviewed as part of the assessment process, and where some relevant individuals were not interviewed, why they were not. Assessment of reliability is considered through the critical analysis of the evidence presented and the collection of sufficient information to be as confident as practicable that the information gleaned is clear and accurate.

The ASWs are then asked to give an assessment of risk, in the light of all factors considered following their assessment of seriousness of danger. This varies, in five stages, between low risk and high risk. Overall Risk which is the final overall assessment, is a combination of the conceptually distinct areas of risk and danger (see Figure 1 for a diagrammatic presentation of the relation between risk and danger in relation to the cases researched).

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## Social Work, Social Science and Practice Wisdom

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### SUMMARY

Social work has for some time had an ambiguous and ambivalent relationship with its social science knowledge base. However, this has arisen, at least in part, because of the emphasis on the outcome or product of social science rather than the process by which research is conducted. This paper, focusing on assessment, argues that an emphasis on process goes some way to closing the gap between social science and social work, that the methods used by social researchers are, in many respects, simply refinements of the methodology of everyday life, and that social workers, when conducting assessments operate rather like practical qualitative researchers. Using Analytical Induction as an *heuristic* device, it proceeds to explore critical characteristics of good practice in social work assessments. It concludes that practice should be characterized by critical awareness, involving imaginative development of alternative hypotheses, a sceptical attitude towards case assessments and a principle of adopting hypotheses least likely to be in error.

Social work practice has, for some considerable time, shared a somewhat ambivalent relationship with its knowledge foundations. On the one hand, practice underpinned by an adequate knowledge base has appeared to offer the glittering prize of secure professional status, one perceived to characterize traditional and high status disciplines such as medicine and law (Goode, 1957; Greenwood, 1957). On the other, the prescriptions of theory have, for many practitioners, often appeared distant, esoteric and hardly relevant for the complex and pressured world of practice. A consequence has been that the confident hopes of many social work writers, documented over some considerable period of time, that social work possessed, or has the potential to possess, coherent knowledge foundations (Greenwood, 1957; Hearn, 1958;

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Meyer, 1959; Bartlett, 1970; Siporin, 1975), has at times been met with cynicism by those who found prescriptions derived from practice experience of considerably greater immediate use. Stevenson and Parsloe (1978), for example, found it rare for practitioners to incorporate theory into their description of their work. Carew's (1979, p. 354) study reinforces this in relation to practice action: 'with this body of practice wisdom as a basis for their activities, the need to use abstract theories and generalizations from research were minimal'.

In relation to social science in general, and sociology in particular, this apparent distance between the prescriptions of the academic discipline and the imperatives of practice prompted an extensive reappraisal of their place in the social work curriculum (Sibeon, 1990). One explanation for this theory-practice dissonance, put forward by Sheldon (1979) in relation to social work theory, but equally relevant to social science, was a 'culture gap' between the academic and practice arms of the occupation. According to this view, nothing in principle prevents social work developing secure knowledge foundations. The problem resides instead in the gap between these subcultures, one concerned with questions of evidence and validity and the other on practice prescriptions, and a refusal amongst the academic subculture to adopt consistent principles—specifically derived from Popper (1963)—for choosing and developing appropriate knowledge forms.

Others, however, have suggested that the problem is far more fundamental. Stevenson (1971), sceptical that social science has developed a consistent body of knowledge, warned social workers against erecting their knowledge foundations on such 'shifting sands'. Howe (1980) drew attention to the paradigmatic and theoretical diversity of social science, as a result of which agreement on the focus and methods of study as well as interpretation of results can be elusive. To a considerable degree, what one 'sees' in social life is dependent on particular perspectives. Sociology and psychology, furthermore, have a poor record of developing general theories helping us explain and predict social behaviour (Phillips, 1973; Hesse, 1978). Indeed, whether this is its proper task is a matter of some controversy. The idea that sociology, for example, can be based on a cumulative and developing knowledge base is anathema to a considerable proportion of the academic community, many of whom suggest that this 'scientific' approach can never adequately represent the human condition (Blumer, 1969; Williams, 1976). Where such uncertainty prevails about the nature, focus and proper tasks of 'pure' social science, its application to practice appears beset by difficulties from the start.

Other concerns have focused on the nature of social work rather than social science. England (1986) suggested the foundation for helping in

social work is understanding others. The precise recreation of meaning and experience of the client is fundamentally an intuitive process; one which is spontaneous, and where the worker is necessarily committing him/herself in action to decisions derived from immediate consciousness. The result is that social workers have no exclusive talents. There will always be people who have an unusually developed, yet untrained, ability to understand others. Formal knowledge of any sort, therefore, has a merely subordinate status; it helps make social workers more sensitive, but is fragmented and should be plundered as appropriate. Howe (1980) likewise considered that the particular human skills required for social work are not necessarily appropriately based on social science. Just as the ability to ride a bicycle does not require an understanding of mechanics, so it is dubious that expertise in social science provides much information about how to react to situations. Indeed, like England, Howe suggested that social work is not recognizable by particular skills in human relationships. Echoing earlier comments by Wootton (1959), he suggested social work would more profitably base its skills on expertise about the welfare state and its resources, involving the ability to know about, handle and impart information.

Davies (1981, 1986) suggested that even those approaches of apparently greatest relevance to social work—such as attachment, inequality and stigma—have been of strictly limited use. Indeed practical constraints rather than any formal knowledge, he argues, have exercised the greatest influence on practice. In any case, he thinks, sociology has provided an unsuitable basis for conducting practice: rightly possessing a freedom to pursue ideas which contrasts with the structural constraints upon social work, and with a critical edge which can too frequently undermine practice rather than enhance its knowledge base. While his more recent writings still reveal caution about the sociology–social work relationship, he has suggested three directions for a sociology of social work: to examine the function of social work in society; to identify what constitutes good practice and to discover means by which practitioners may be restricted from pursuing their own goals at the expense of the agency and client.

Others have expressed greater confidence in the social work–social science relationship. Sibeon (1990) has castigated Davies for his failure to recognize the potential contribution of micro sociology and the futility of his attempt surgically to remove the social sciences from social work. Hardiker has been equally dismissive: she (Curnock and Hardiker, 1979; Hardiker, 1981) argues that practice theory is implicit in their conduct of practice, and she feels the predominant practice ideologies have been teased out: without this theory, practice is considerably poorer. However, it is not clear that these ‘theories’ are not simply

those used by individuals in everyday life to make sense of, and act upon, situations, or that they are extensions of these everyday theories made in the light of the social work role, task and context. Sheppard's (1991) research does, however, suggest that professional training and the theory which goes with it, has an impact on practice, and his comparison in this respect of social workers with community psychiatric nurses renders this claim more plausible. Sheldon (1986, 1987) and McDonald *et al.* (1992) meanwhile have strongly advocated the incorporation of findings from evaluative studies in the curriculum.

However, attempts to formulate a consistent process for application have been less convincing. Sheldon's adoption of the hypothetico-deductive method has been criticized for its particularism which effectively excludes an array of potentially useful approaches (Jordan, 1979). Sheppard's (1984) suggestion that practitioners should make choices based on the values, theoretical framework, methods and consistency of findings hardly represents a practical approach for busy social workers, while clearly demonstrating the complexity of the task of application. His later (1990) advocacy of the adoption of theoretical approaches consistent with the structural constraints on social work, together with principles of congruence and specificity, carries more conviction because the task is carried out by researchers rather than practitioners, who are presented with pre-designed instruments.

Although differences of view, therefore, exist on the contribution or potential contribution of social science to social work, one theme permeates all approaches: that limits exist to the applicability of social science to social work and that this arises because of their different characteristics. These points, however, arise in relation to the given knowledge of relevant disciplines: the theories, ideas and research findings available in the existing literature. They represent *outcomes* or *products* of the endeavours of social scientists. Little attention, however, has been given to the *process* by which research is conducted, and how this might inform practice. This is perhaps surprising, because the concern of the researcher, as much as the practitioner, is to understand, and at times explain, the social phenomena with which they are concerned. Sheldon (1983) has suggested the use of single case experimental designs in this respect, expressing a concern about 'over reliance' on qualitative terms and advocating the use of experimental methods in practice.

However, many would argue that such experimental approaches fit poorly with the reality of the social world (Blumer, 1969; Williams, 1976; Bulmer, 1979) and this essay draws on a different tradition. It is the contention of this essay that social workers, when conducting assessments and attempting to make sense of situations, have much



in common with qualitative social researchers. Indeed, they may be considered in many respects, to be *practical* qualitative researchers. Such a contention has major implications, for it at once closes the 'theory-practice gap', while recognizing that it does so in only one area of the theory-practice relationship, and in relation to certain aspects of practice. These are, however, important aspects. It is presented, furthermore, as a contribution to one of Davies' (1991) central concerns: how we recognize what constitutes good practice.

This essay will argue that the proclaimed gap between social science and social work is, in certain key respects, incorrect; that the linking factor is the common methodology for understanding and reflecting upon situations; that it is this commonality which allows us to accumulate practice knowledge (or wisdom). Having established certain key commonalities between social science and everyday life the article will seek to understand similarities and differences between social research and practice wisdom, and to identify what constitutes good and bad methods of practice wisdom accumulation. Analytic induction, with its case based methodology, is used as an heuristic device for this purpose. Within a qualitative approach in which social understanding can, at best, be probabilistic social work assessments are presented as (a) a retroductive process of hypothesis generation, testing and reformulation (or redefinition of problems), (b) with an underlying principle of minimizing the likelihood of error and (c) characterized by an approach involving routine scepticism and critical awareness.

## SOCIAL RESEARCH AND HUMAN UNDERSTANDING

### NATURALISM, POSITIVISM AND THE PRIVILEGED POSITION

The notion of applied social science is based on the application of knowledge derived from the process of social research. The theory-practice separation, where social workers' presence in the 'real world' is contrasted with social scientists' abstracted, conceptualized version is, though less commented upon, neatly reflected amongst many social researchers. Despite differences in other respects, many researchers of both positivist and naturalist, though not realist (Silverman, 1985; Bhaskar, 1975, 1979) persuasion, tend to present the social researcher, whether explicitly or implicitly, as occupying a 'privileged position'. This privileged position, for different reasons, leaves the social researcher as an 'outsider' to the social work s/he is studying. In the case of positivism, every attempt is made to eliminate the effects of the

observer by developing explicit standards of experimental or interview procedures (Toulmin, 1972). This allows replication by others so that an assessment of reliability of findings can be made. In survey research, for example, the behaviour of the interviewer is specified down to the wording of questions and the order in which they are asked. The resulting data yield 'facts' about the world. The aim of the interviewer is to generate data which hold independently both of research setting and researcher (Srellitz *et al.*, 1964).

There is a related, though less well documented and implicit, tendency among naturalists (a loose group of interactionists, ethnomethodologists and phenomenologists). One of the most significant assumptions built into naturalism, according to Hammersley (1992), is that all perspectives and cultures are rational. Understanding a culture becomes the first requirement, and any attempt to explain in terms of material interest or ideological distortion is regarded as incompatible with such understanding. The result is a thoroughgoing relativism, accepting different perspectives as equally valid and 'true'. Anything more would require explanation of perspectives and cultures—the product of social causation rather than the active construction of reality by members. This is a paradoxical conclusion. While culture members freely engage in checking claims against the facts, frequently employing causal explanations to account for each other's behaviour, the social researcher is debarred from this on the grounds that this would 'distort reality'. This entails a distinction between 'science and commonsense' which also lies at the heart of positivism. As Hammersley and Atkinson comment, both positivists and naturalists are thereby granted a 'privileged position':

the distinction between science and commonsense, whether used by Positivism or Naturalism, tends to imply that science is quite separate from society, and that scientists, *qua* scientists, are quite different from other people (Hammersley and Atkinson, 1983, p. 14).

This clear tendency among both theorists and practitioners to separate social research from the 'real world' undermines attempts at synthesis (of theory and practice). However, the social researcher cannot possess the privileged position of 'outsider'. It is quite simple: as human beings social researchers are necessarily part of the human world they study. This is not a matter of methodological commitment, but an existential fact (Borhek and Curtis, 1975; Gouldner, 1970). Deprived of their privilege, the social researcher joins the social worker in the rough and tumble of 'insider'. Both are captured by their common human status. The role of social researcher, furthermore, is that of active participant in the research process (Schuman, 1982). The way people respond to

the presence of the researcher is an important aspect requiring consideration when attempting to make sense of the phenomenon studied (Keat and Urry, 1975).

#### THE METHODOLOGY OF EVERYDAY LIFE

Social researchers are, then, 'captured' by their common human status. A further implication follows: that they cannot avoid relying on 'common sense' knowledge. 'Common sense', in this respect, refers to the way in which we, as human beings make sense of the world. However distinctive the purposes of social research, the methods it uses are merely refinements of those used in everyday life. This is perhaps obvious with ethnography. Hammersley and Atkinson (1983) again relevantly comment:

As a 'structured conversation' the interview is by no means unique to social research. While the journalistic interview, the social work interview, the market research interview and the social science interview each carry distinctive features, they are clearly features of a single interactional format.

Clyde-Mitchell (1983) also draws attention to the basic similarity between case material collected and analysed by practitioners, including social workers, and social scientists. The same applies, if less obviously, to the experiment. While lab experiments characterize lab scientists' work, the general device of experimentation is widespread. Medawar (1979, p. 69) comments that, in the original Baconian sense, experiments are contrived occurrences as opposed to natural experiences or happenings. Experiments are questions put to the world 'what would happen if?' This kind of testing is common in everyday life—the laboratory experiment was originally simply a refinement—perhaps encapsulated in the term 'trial and error'. If crackling noises replace a clear signal on my car radio, I might first wish to adjust the frequency (hypothesizing a 'slippage' from the correct frequency). If this does not work I may check connections on the aerial (are they loose?). If this does not work, I may conclude either that the radio is broken (if only crackling can be heard) or that the station is off the air (if other stations may be heard).

Testing hypotheses, then, is not restricted to science or social research, but is an aspect of everyday life. It is also central to understanding others' actions: a key element of both social research and everyday life. Infants may cry because they are, for example, hungry, or in pain or have wet themselves (Dunn, 1978). Without precise communication, we must work through the ambiguity to understand the message. If it is about feeding time we may attempt

to feed the infant. If they are uninterested we may try another option: that they are wet. If this is not the case we may conclude they have 'wind' and gently tap their back. If they stop crying we may conclude that we have understood (and responded to) the correct message.

When we observe others' behaviour we derive hypotheses from our cultural knowledge and we test this against further information. This, in effect, means that our understanding of communication is dependent, at least in part, upon the situation in which it occurs. The infant's crying may be set against the context of infant-caregiver relationship. Behaviour in one context does not necessarily mean the same as that in another (Silverman, 1985, p. 21). A raised arm in a restaurant may involve attracting a waiter's attention; on a football pitch the recognition of a goal scored; in a schoolroom it may indicate a student wishes to answer a question or go to the toilet, or something else.

Everyday language has a name for this methodology of hypothesis testing—trial and error—so we also have a name for poor methodology—jumping to conclusions. Here an individual derives an incorrect meaning from a situation by inadequately considering alternative possibilities explaining a particular behaviour. If two people are engaged in deep conversation about matters important for one of them, who does the most talking, the listener may close their eyes and be quiet. After a while the talker may conclude the listener is asleep, indicating lack of interest in their concerns. If they berate the listener for their disinterest (and somnolence), they may be surprised to find the listener was awake all the time, closing their eyes the better to concentrate. Such actions indicate the importance attached by the listener to their concerns rather than the reverse. The listener may justifiably berate the talker for jumping to conclusions.

The common availability of language distinguishing between adequate and inadequate methods of gaining social understanding implicitly recognizes the importance of reasoning in everyday life. 'Jumping to conclusions' refers not only to inadequate hypothesis testing, and distinguishes good and bad methodology, but is also a term of denigration. The processes employed by social researchers are, in certain, if not all, critical respects embedded in the conduct of everyday life, particularly in non-routine social situations or when information imparted is not self-evident. When a statement is ambiguous we will search for its meaning: is it a sarcastic or straightforward comment? are they joking? are they lying? and so on (Brown, 1973). In Payne *et al.*'s (1981, p. 126) memorable phrase, 'social actors are depicted as rule using analysts rather than rule governed dopes'.

SOCIAL WORK AND SOCIAL RESEARCH  
METHODOLOGY

## ANALYTIC INDUCTION

The similarity, in certain key respects, of social research methodology and that of everyday life undermines, in these respects, proposed dichotomous relationships between social work and social science. For social workers are as much captured by their common human status as social researchers. At the same time, however, it may, *in part*, explain why many practitioners devalue social research and value life (or practice) experience rather more. It is possible to understand situations, and learn from accumulated experience, in a way, at least in principle, helpful for practice. The limited applicability of social science leaves a space filled by knowledge derived from accumulated experience. It is, paradoxically, the *absence* of a gap between the methodology of social science and understanding everyday life which allows experience a crucial role. Yet Sheldon (1987) has warned of the consequences of humans' tendency to confirm their preconceptions. He suggests stricter tests of social work perceptions, assumptions and decisions, advocating goal setting, timetables and in particular hypothesis setting in practice. If, then, social research and developing everyday knowledge are, in certain methodological respects, similar, can we learn anything from the methodology of social research? In particular, can it tell us anything about the nature of practice wisdom, and what constitutes good methodology in practice (i.e. distinguishing good from bad practice)? This question involves switching our attention from the results of social research to its *process*.

Social workers, when making assessments, confront the world rather like qualitative social researchers. They are concerned with issues of description, accuracy, understanding and meaning, and this information is gained largely through interviews, direct observation and documentary evidence (Burgess, 1985). One major approach to qualitative methodology is Analytic Induction (AI), a method by which qualitative researchers try to formulate generalizations that hold across all data. Originally formulated by Znaniecki (1934), it has been used or examined, largely favourably, by Robinson (1951), Lindesmith (1952), Denzin (1978), Bulmer (1979), Hammersley and Atkinson (1983), Silverman (1985) and Burgess (1985). It is relevant in three key respects: it is qualitatively focused, like most social work assessments, it is case based, and it seeks to generate generalizations from case analysis, an approach which is similar to developing practice wisdom. It should be emphasized, first, that AI is not without its critics, and second

that it is being used as an *heuristic* (and comparative) device. It is not suggested that practice wisdom development is Analytic Induction.

A necessary interplay, between data and (often implicit) theories providing explanatory frameworks is generally considered as significant for practice understanding as social research (Howe, 1987; Payne, 1991; Sheppard, 1984; Curnock and Hardiker, 1979). This interplay involves, in social research, according to Bulmer (1979), a process of retrodution. This process, he thinks, is exemplified by AI. This holds that theories are not developed deductively or inductively, but both deductively and inductively. There is a constant interplay between observation of reality and formulation of concepts, research and theorizing, perception and exploration (Lachenmeyer, 1971, p. 61). According to Hanson (1958) this is simply represented as: the observation of some phenomenon, *P*, is explicable if *H* obtains. So let us suppose that *H* is true.

It is at this point a reasonable supposition, nothing more. From this we may further examine data on the basis of hypothesis *H*. Bulmer (1979, p. 659) argues that this is consistent with the generation of understanding: neither theory nor data can be arbitrarily separated out in the process of exploration. To begin to make sense of phenomenon *P* (a child's behavioural problems) some idea of its cause (e.g. anger) is required. This may be later amended to some notion of poor attachment. The point is theory is *immediately* required to make sense of the data. Concepts are neither developed out of observation, nor are they imposed *a priori*. They are interdependent.

This progressive development of hypothesis construction and data analysis has its equivalent in social work: the initial supposition of retrodution is paralleled by the use of 'hunch' in social work (England, 1986), and its progressively more accurate formulation would characterize practice where the worker subjected the 'hunch' and subsequent hypotheses to analysis in terms of the actual situation. Bulmer's (1979, p. 662) description of this as exemplifying 'the muddling tentative way in which the so-called scientific mind gets ahead' is one social workers will readily recognize in relation to practice.

The central purpose of AI is the development of hypotheses which hold across all examples of the problem (e.g. drug addiction). The process involves a systematic search for a 'decisive negative case' (Lindesmith, 1952, p. 195). If a theory is false or inadequate the researcher knows this approach will more quickly expose weaknesses: 'it forces the sociologist to formulate . . . his (!) theories in such a way as to indicate crucial tests of the theory and permit the explicit search for negative cases' (Denzin, 1978, p. 197). We will, in other words, realize, or more quickly realize, if we are wrong. More formally, Robinson presented the approach as follows:

1. A rough definition of the problem to be explained is formulated.
2. An hypothetical explanation of the phenomenon is formulated.
3. One case is studied in the light of the hypothesis with the object of determining whether the hypothesis fits the facts in the case.
4. If the hypothesis does not fit the facts, either the hypothesis is reformulated or the phenomenon to be explained is redefined so that the case is excluded.
5. Practical certainty may be attained after a small number of cases has been examined, but the discovery by the investigator, or any other investigator, of a single negative case disproves the explanation and requires reformulation.
6. This procedure . . . is continued until a *universal relationship* is established, each negative case calling for a redefinition or reformulation (Robinson, 1951, p. 812).

Its logic is clear: it is only by excluding error that we may hope to develop generalizations. While generally supporting its relevance and usefulness, some theorists have identified limitations to AI, which are considered later. This, however, may be set alongside its great theoretical strengths—clear hypotheses, a method of hypothesis development, interdependence of theory and data and its emphasis on eliminating error—and practical relevance—an emphasis on the case and qualitative methodology—in considering social work practice.

#### CASE ASSESSMENT

As an heuristic device, AI can help us consider two related elements of practice, case assessment and the development of practice wisdom. Stages 1–4 of AI correspond to the specific case, rather than the production of generalizations. These relate to the degree of ‘fit’ between hypotheses and evidence. How might social work assessments look when guided by these principles? Three themes are evident for practice: clear hypotheses, the search for disconfirming data and reformulation of hypothesis or redefinition of problem in the face of disconfirming evidence. AI concentrates on what we shall call *progressive hypothesis development*. This is characterized, in practice, by a step by step process of examining hypotheses one by one, abandoning those which confront disconfirming evidence, until one adequately fitting the data is developed. An alternative, in practice, may be *comparative hypothesis assessment*. Here, a number of competing hypotheses may be used to identify their ‘fit’ with the data. These may be explored through an example.

*Progressive hypothesis development:* A 14 year-old may be referred by his (the use of the male pronoun is arbitrary) parents because he is

disobedient and close to being 'out of control'. He has been stealing money from his mother's purse, truanting from school and is increasingly aggressive. According to the referral he is also taking less and less notice of what his parents are saying, staying out whenever he likes and becoming involved with known young offenders. The parents may themselves present this as a personality issue: this is an awkward life stage and a nasty egocentric boy. As a loose initial hypothesis (presenting problem) this can be examined by seeking evidence. Initial interviews with him may show him to be more sensitive than presented by the parents, displaying a concern for the way he is drifting and an awareness that his parents are understandably exasperated by his behaviour. Such evidence negates simple explanations of egocentricity. We may then search for alternatives, examining family dynamics. We may discover that his mother has been increasingly 'snappy' over the past year, has, unlike in the past, shown no interest in what he is doing and communicated this lack of interest dismissively and with verbal aggression. Both parents have been arguing. Such a line of investigation contains an implicit hypothesis that the parent-child relationship is poor, this is affecting the boy and leading to 'difficult behaviour'. Far from being egocentric this reflects sensitivity to his familial circumstances. Further investigation may reveal the father and mother have been arguing frequently, and this relates to poor performance of her traditional (maternal) role. Additional investigation may show she is alienated from this role, feels trapped within it, that life holds very little for her. She alternates between desperation and anger at her situation. We may then hypothesize that the woman is depressed because she feels trapped within the limits of her traditional role expectations. Although the problems of the boy cannot be ignored, the central problem is in fact the mother's depression, arising from her individual experience of oppression.

This approach—progressive hypothesis development—is evident from the move through hypotheses from egocentric personality through family disruption to depression and oppression. It illustrates the critical nature of disconfirming evidence and why adequate assessment cannot be a matter of seeking confirming evidence. The initial definition of the problem was of a disruptive, possibly delinquent teenager, and the hypothesis was of an egocentric, rule-ignoring personality. Had the practitioner sought simply to confirm this hypothesis, they could have ignored disconfirming evidence, or 'fitted' it with the initial hypothesis: the boy merely presented himself as sensitive in a calculated attempt to throw them off the track. However, the practitioner was both aware of the contradictory way the boy presented himself, and by examining wider (familial) issues implicitly sought disconfirming evidence which



at the same time would provide the basis for the generation of new, more adequate hypotheses. This connection, between assessment, disconfirming evidence and hypothesis (or problem) reformulation, broadly provides a practice reflection of AI in social research.

*Comparative hypothesis assessment.* In practice the social worker may approach matters with various areas which they wish to explore: the boy's personality, behaviour of each parent, marital relationships and family dynamics. These may contain a number of implicit, but competing, hypotheses each of which may be examined in relation to the evidence gathered. The process of exploration does not start here from a single reference point, and this would reflect the availability to the worker of different potential perspectives on the nature of the problem and its explanation. The process of assessment would take place in a way that allowed the total range of evidence to be used to falsify (potentially) any of the hypotheses. Lindesmith (1952, p. 492) argues that AI involves 'going out of one's way to look for negating evidence'. Competing hypotheses, implicit in assessment, for example of wider family dynamics as well as the boy's personality would, by analysing a range of evidence, enhance the opportunity for finding disconfirming evidence. Evidence of family disharmony both directs us to reformulate the problem and contradicts the implicit unidimensional explanation inherent in focusing on the boy's personality.

Each competing hypothesis may be examined in terms of the adequacy of 'fit' with the evidence collected. If, for example, the boy really did display great egocentricity with no other apparent affective or behavioural problems in the family we might move towards a 'personality disorder' explanation. Here, falsifying evidence would be obtained, not in relation to the boy's egocentricity, but to familial issues generating alternative hypotheses. Comparative hypothesis assessment, then, contains similar principles to progressive hypothesis development: emphasizing disconfirming evidence, sceptical attitude and 'adequacy of fit'.

An emphasis on hypotheses contains two clear commitments: to precision and being explicit about the hypotheses developed. Where hypotheses are not precise this may render falsification difficult, if not impossible. It would, for example, be perfectly possible for a practitioner to develop a general hypothesis that the adolescent's 'personality' was responsible for the behavioural problems identified. However the particular aspect, or aspects, of personality involved may be obscured by such a general formulation. The behaviour may be the result of a depressive dimension, or of an individual dependent on the good opinion of a peer group who encourages his behaviour (or indeed of an egocentric personality). Poor practice is marked by a lack of clarity in

hypothesis formulation. The search for disconfirming evidence is made difficult by the difficulty in identifying what it is that is being disconfirmed. Furthermore, assessment has implications for intervention: a depressive personality may involve quite different approaches from one involving overdependence on peer group opinion.

Hypotheses, secondly, provide a focus for both knowledge based on social science research and ideas, and knowledge based on life or practice experience. It is perfectly possible, for example, for a practitioner to draw upon experience they have had as the aunt of an adolescent with similar problems, or indeed, as a person who has experienced the angst and problems of teenage years. They might also draw upon their experience of family life, as a daughter and perhaps as a mother with her own family. Areas of social science knowledge have obvious relevance: for example that relating to the sociology and psychology of adolescence and the complexities of family life (Rutter, 1979). The example is interesting for one area—the oppressive—depressive dimension to the mother's life—where social science knowledge is likely to be particularly significant. It is, of course, possible for the worker to draw upon her own experiences as a woman, and those of others she knows, to develop awareness of this oppression. However, an assumptive world, characterized by traditional role stereotypes, because it effectively excludes consideration of non-traditional alternatives, renders consideration of these alternatives literally unthinkable. The feminist literature, and that specifically linking oppression to depression (Oakley, 1975; Scanzoni, 1978; Parry, 1987; Corob, 1987), provides the opportunity to make wider sense of the situation, allowing a praxis between her experiences as a woman, and those of clients and others she knows, and feminist ideas.

Sensitivity to disconfirming evidence has two dimensions. First, it is possible for a practitioner to proceed in a manner which seeks to confirm initial impressions or preconceived ideas. This 'verificationism' can amount to confirmation of prejudices with potentially disastrous consequences, as in the case of some disclosure interviews with young children (see Furniss, 1991) where fears that children may be 'led' into inaccurate disclosure of non-existent sexual abuse have been voiced. The second relates to evidence, although collected during assessment, which, because it contradicts explicit or implicit hypotheses, is ignored. While potentially as serious as the first dimension, it is potentially more rectifiable. Because contradicting evidence is available the potential exists, without examining methods, to question the conclusions reached on the basis of available evidence. In the first case disconfirming evidence is not available: all the evidence accumulated is for the purpose of confirming particular hypotheses. Only by critical examination of

methods of assessment and/or identification of possible relevant areas of assessment which have been missed can the misleading and inadequate nature of assessment be discovered.

These instances represent the professional equivalent of 'jumping to conclusions'. Interestingly, there is some evidence from the supervisory role of social work seniors that a significant task is encouragement of adequate assessments (Gadsby-Waters, 1992). Systemized in this way, their task is about (a) identifying where evidence contradicts hypotheses, (b) identifying potentially relevant areas which have been ignored, (c) whether methods used simply confirmed inadequate formulations.

### ASSESSMENTS AND PRACTICE WISDOM

Practice wisdom may be defined, for our purposes, as the accumulated knowledge practitioners are able to bring to the consideration of individual cases and their practice in general. This would appear to have three main and distinct potential sources: knowledge gained from 'everyday life', derived from the process of living in society and interaction with others; knowledge gained from social science, specifically research and ideas; and knowledge gained from the conduct of social work practice. This latter involves two elements: knowledge gained through assessment and working with a number of cases involving the same problem and knowledge gained through work with other problems which possess dimensions, the knowledge of which is (potentially) transferable to the particular problem at hand. These, it should be emphasized, are presented as the main sources of practice wisdom: individuals may, for example, make use from time to time of medical knowledge, particularly if working in a health setting. Although all stages of AI may be used heuristically to consider practice wisdom, stages 5 and 6, concerned with the production of generalizations, appear particularly relevant. With AI these generalizations would relate to particular classes of cases (e.g. drug addiction), and would be applicable to individual instances (cases) within that particular class.

### PROBLEM BASED PRACTICE WISDOM

We may usefully consider Lindesmith's (1947) example of drug addiction, using AI, because of its obvious relevance for practice. His hypotheses concerned the specific circumstances for the creation and maintenance of drug addiction; his conclusion that addiction occurs only when distress is associated with conscious awareness of its relationship

with the absence of drug use. Two issues arise: its usefulness and comprehensiveness (as opposed to universality). While these hypotheses may be universal, they offer little help to practitioners attempting to end the addiction. They can hardly, without medical help, allay withdrawal distress, and certainly cannot dispense with conscious awareness of it once established (through conventional social work methods). Second, the limited scope of the hypotheses means they do not cover a range of areas which may be significant for 'kicking the habit'. These could include triggering factors such as unemployment, feelings of anomie, symbolic meaning of drug taking, peer group pressure and so on (Akers, 1991; Berridge, 1989; Goldberg and Stollerman, 1986; Dorn and South, 1985, 1987). All these may be relevant to the commencement and maintenance of drug taking.

Many of these factors may be frequently, *but not universally*, present. This seems to involve a distinction between universally applicable hypotheses, as, for example, claimed by Lindesmith, and hypotheses of limited generality, relevant to some, but not other cases. For example, not all drug addicts are unemployed (and vice versa). The use of crack and cocaine in city financial circles indicates drug addiction amongst relatively wealthy individuals: here the stresses of the job have been considered contributory to drug addiction. This has considerable implications. Rather than the progressive elimination of error, which AI aspires to, factors are included which are present at some but not other times. We may find that anomie is universal to unemployed addicts, but not city financiers. This appears to involve a further dimension: classification within particular problem areas. There is, however, a danger of infinite regress here. If we find some, but not all, drug addicted city financiers suffer anomie, we would seek to distinguish the two by some further associated factor. This kind of continuous segmentation is difficult enough for researchers (see e.g. the summary of Brown's work on depression, Brown, 1986); it is practically impossible for practitioners. In the pressured world of practice we are more likely to occupy the realm of the probabilistic. In developing awareness of the kind of circumstances in which particular hypotheses are *likely to be relevant*, we will have distinguished between the applicable and non-applicable. In practice, generalization to all cases would anyway require a degree of precision not available to the practitioner. They are more likely to perceive the lessons of experience in more general terms of trends, tendencies and likelihoods.

In fact there may be less difference between social research and practice than it appears; the certainty claimed for AI through the progressive elimination of error may be illusory. Two criticisms have been made by those otherwise impressed with AI (see Robinson, 1952; Turner, 1953;

Bulmer, 1979; Silverman, 1985). AI tries to create a 'closed system' by identifying factors always present with phenomenon P, but never without it. However, multiple factors (e.g. family integration) also associated, but variantly, with the phenomenon will not be part of the closed system. They will neither be assimilated in the system nor have a uniform effect, and are, relative to the closed system, intrusive factors. Any prediction must, therefore, be probabilistic. Second, AI aims to identify, with certainty, conditions universally accompanying some phenomenon. This, however, implies prediction, which has been refuted by both Hume (1975) and Popper (1963). Put simply, this means that no amount of observations confirming the association between some phenomenon and certain conditions can 'prove' an association between them, because at any time in the future an observation may occur which falsifies this association. It may, therefore, be useful to distinguish between practical certainty, as espoused by Sutherland (1939), and absolute certainty. Knowledge is necessarily provisional: at any point in the future an observation may occur which falsifies an association between some phenomenon and its associated conditions.

For social work, if we stick to our general principle of attempting, as far as possible, to eliminate error, then its probabilistic equivalent is choosing hypotheses *which are least likely to be wrong*. This would apply to individual case assessment as well as the development of practice wisdom. This entails, in any particular case, first, identification of factors least likely to be absent and second, an appropriately sceptical attitude to those we use, as described in the previous section. The dangers of verificationism in individual cases are writ large with practice wisdom. The process of confirming preconceived ideas can be cumulative and self-reinforcing: practice wisdom is brought to the case; that case 'demonstrates' a particular hypothesis; the evidence from the case reinforces the already established practice wisdom. A potential example of this is the schizophrenogenic mother, generating schizophrenia through a 'double bind' (Bateson *et al.*, 1956). This idea gained currency in practice circles, yet research has shown no evidence of its aetiological significance (Rinquette and Kennedy, 1966; Haley, 1968).

#### PRACTICE WISDOM AND TRANSFERABLE KNOWLEDGE

We have, therefore, the probabilistic equivalent of universally applicable hypotheses, a distinction between general and limited hypotheses and a principle of least likelihood of error. A second form of practice wisdom is generic/transferable practice wisdom. This occurs when the definition of the problem in separate cases is quite different, for example unemployment and bereavement, but knowledge may be

transferred across them. This combination of (surface) difference with (below surface) similarity marks out generic knowledge. The key is the 'below surface' similarity between cases. For example, a 50 year-old man made redundant and an elderly bereaved woman, whose overt problems are different (unemployment and bereavement) may both have feelings of loss and possibly depression. In this case the rather obvious example is loss. If, indeed, both unemployed man and bereaved elderly woman suffer depression at least three 'layers' exist: unemployment/bereavement; loss; depression. Generic concepts, however, have limited universality of a type different from that described earlier. They facilitate the transference of knowledge across apparently different situations, but the knowledge as applied to one situation, is not completely transferable to another. The 50 year-old redundant man may feel loss and depression (Warr and Jackson, 1985), but this may be lifted if he is immediately offered a new job. Having lost her husband, however, the elderly woman is unlikely to recover if someone immediately asks her to marry him (Argyle and Henderson, 1985). Unless her relationship was badly damaged, a grieving process would normally separate actual loss from the capacity to begin a new relationship. Only when this has occurred is she likely to feel able genuinely to enter a new relationship (Marris, 1974).

## PRACTICE FOLKLORE AND SOCIAL RESEARCH

### PRACTICE WISDOM AND SOCIAL RESEARCH: SOME DIFFERENCES

Practice wisdom, therefore, is optimally developed through a retroductive process of hypothesis testing and reflection, involving an approach to evidence which is sceptical, and a principle of adopting hypotheses which are least likely to be wrong. The quality of practice wisdom—indeed the extent to which practice experience may allow the development of practice wisdom—is, it is being suggested, dependent to a considerable degree on the extent to which a practitioner's work is characterized by these particular qualities. It is in how this process is accomplished that social work most clearly differs from social research. Knowledge based on social research, first, develops through reports and publication. Much of the learning which goes on in practice occurs without recourse to writing reports. Practitioners may engage in individual reflection on particular cases, or engage colleagues in discussions. Where they do write, it may simply involve case recording. Where social workers do write *practice* reports, such as social enquiry reports (Hardiker, 1975; Curnock and Hardiker, 1979), they are unlikely to

write them in a way that makes explicit practice learning by hypotheses testing. Reports are not written primarily for the purpose of developing knowledge of specific phenomena (say, drug addiction) but to provide information of a particular client or case. The writing of the practitioner's report is generally case focused; that of the researcher generally phenomena focused. There is a sense in which knowledge accumulation is a byproduct of this assessment process.

Much of the practice wisdom developed by workers is not written down or chronicled. The result of this is a tendency towards 'personalized knowledge' or 'practice folklore'. This is knowledge which is known to the individual alone rather than generally available (through perhaps books) or knowledge which is passed round primarily by word of mouth, becoming, through this, accepted canons of practice amongst those party to this knowledge. This contrasts with report writing, particularly published work in social science, whose primary purpose is the presentation and development of knowledge of specific phenomena. Popper (1972) discusses the process through which research and ideas take on a life of their own: they exist separate from their author and are available to wider audiences than those with immediate access to the author. Without this wider access, therefore, practice wisdom is much more subject to the vagueness of memory and recall. Although there may be some separation of ideas from practitioners, where for example discussed within teams, this is limited compared with social research. Knowledge is, furthermore, less likely to be developed systematically. The social worker may, without the opportunity (perhaps inclination) to write down their learning, be unable to identify what makes two apparently similar situations sufficiently different for different hypotheses to apply. This would reflect both the limits to classification identified earlier and also, perhaps, a limit to the degree of precision which may be achieved when not relying mainly on documentation whose primary purpose is the development of knowledge about the phenomena, a major aspect of which is precise, accurate identification of relevant variables, which may be subsequently built upon.

#### THE 'PRACTICE COMMUNITY'

A further dimension of practice folklore shows both similarity with and difference from development in social research. There is a 'practice community' which occupies a roughly equivalent role to that of the 'academic community'. Both have tasks of exploration and checking validity. Exploration may occur where a practitioner, facing the problem of 'making sense' of a situation, or deciding on appropriate intervention, engages others to consider alternatives. Is this parent really

telling the truth about the accidental nature of their child's injuries? What are the kinds of things we should look for in order to minimize the possibility of error in making assessments? Are there any aspects of the case allowing us to establish matters beyond reasonable doubt? Formally, this is one aspect of supervision, but it may occur informally with colleagues.

Checking validity may occur at the same time as exploration: how far are my initial conclusions justifiable in view of the evidence presented? is there any falsifying evidence? are there alternative explanations? and so on. The process of checking validity may be more or less systematic, its quality depending on the critical faculties of those engaged in the debate, and their practice wisdom. This process is, very broadly, similar to the process of scrutiny in academic research:

the research community plays (or should play) a crucial role in checking the validity of findings of particular studies. This process is at the heart of the justification of research as a source of knowledge . . . [which] rests on the claim that research based knowledge is less likely to be in error than information from other sources because it is subjected to scrutiny in terms of higher levels of *routine scepticism* [my italics] than is common outside the academic community . . . it is this rather than any appeal to a concept of brute data . . . that is the major rationale for the intellectual authority of research (Hammersley, 1992, p. 91).

This emphasis on routine scepticism, evident in our examination of case analysis, is also involved in this concept of 'practice community'. To develop this however, within a practice community, it is necessary for *individual* practitioners to develop appropriate scepticism in their work. If research is superior to other sources of knowledge because this scepticism is allied to peer scrutiny—research is facilitated in this respect by explicit reporting of methodology, results, and frequently assumptions underlying studies—then the adoption of its basic processes by practitioners may be expected to leave practice and practice wisdom more systematic and less likely to be in error.

The nature of practice is such, however, that there are, perhaps inevitably, differences from peer moderation of social research. The 'folklore' nature of practice wisdom means that it is liable to be more idiosyncratic and team based rather than available to the whole practice community (as an equivalent to academic community). Any 'practice community' is more parochial and based around teams. Insights generalizable more widely to practice are rarely written down and almost never widely disseminated. It is liable, therefore, to be subject to more *ad hoc* and informal means for evaluation than social research.

The quality of 'practice community' wisdom is dependent on the quality of practitioners constituent of the community. This quality might be



called critical awareness, entailing the capacity to hypothesize, to be imaginative in developing the range of hypotheses and to subject these to critical assessment (i.e. reject those most likely to be in error). Such critical awareness distinguishes mere experience from its intelligent use. It is possible for someone to have five years' experience and learned little, and for another to have had one and learned much. This interestingly identifies a problem amongst those whose experience is not marked by its intelligent use; that the very lack of critical awareness leaves them less able to judge the quality of, and limits to, their practice wisdom. J. S. Mill comments that it is better to be a Socrates dissatisfied than a fool satisfied, precisely, because of the more developed intellectual faculties of the former. Where a dispute exists 'if the fool . . . [is] of a different opinion, it is because they only know their side of the question. The other party to the comparison knows both sides' (Mill, 1972, p. 9). We may conjecture that these practitioners will be characterized by a greater rigidity in explaining matters, a tendency to transfer explanations from different, though apparently similar situations to another; a lack of consideration of alternatives in different cases; and possibly a downgrading of social science knowledge as a useful source for alternative hypotheses.

This has implications for team processes. It suggests three aspects of the 'ideal' team: practitioners who are characterized by their critical awareness; clear opportunities for informal discussion of case assessment and management, together with willingness among team members to engage in this; clear opportunities for supervision or consultation with those who have a greater fund of practice wisdom.

## CONCLUSION

The switch from a relationship between social science and social work which emphasizes its product to one which emphasizes processes of social research presents a potentially fruitful way to proceed. There is a rigidity about this relationship when primarily emphasizing product: relevant knowledge is either available or it is not. Indeed such a relationship understates the developmental and essentially provisional nature of our knowledge of the world. Furthermore the degree to which it is precisely applicable in any particular instance may be problematic. Howe (1980) has commented that social science is ill suited to a social work approach whereby our knowledge base can tell us with some certainty that if problem *A* is present, and approach *B* is applied, *C* will be the outcome. This presents social work with a relationship with its knowledge base analogous to that existing (or believed to exist) in

medicine, one which is impossible to sustain once we enter the real world of social work practice.

This does not entail entirely discarding the product of social science. There may be circumstances in which social research provides reasonably solid foundations for practice. Any practitioner wishing to target high risk groups for maternal depression for preventive purposes would be considerably aided by the research of Brown and his colleagues (Brown and Harris, 1978; Sheppard, 1990). Likewise, ideas from social science, many have argued (e.g. Howe, 1987; Hardiker, 1981) provide ways of thinking about practice which can be helpful to social workers, particularly when grappling with complex situations. Indeed, these three areas—social ideas, the results of social research and the process of social research—appear to represent the different ways in which social science may inform practice.

The emphasis on systemizing practice wisdom, none the less, reflects less optimism about the application of research findings than is evident in some quarters (MacDonald *et al.*, 1992), drawing, as it does, on the traditions of qualitative sociological methodology rather than the more positivist scientific tradition (Smith, 1987). It is important to appreciate that we are not confronted with a stark choice of applied research findings, which may appear of limited use, and poorly formulated practice prescriptions. Practice wisdom should be just that, not practice prejudice.

The emphasis on choosing the alternative least likely to be wrong may be considered by some to represent an overcautious approach. However, given the tremendous responsibilities of social workers, and the appalling consequences at times of getting things wrong, as is evident from child deaths where social workers were involved, such apparent caution may not be misplaced. Indeed, where the 'product' knowledge foundations are so uncertain, an emphasis on avoiding error appears quite appropriate. Furthermore, the dangers of verificationism are real enough. Festinger (1957) showed some time ago that if we are not disposed to identify with something, we are able, mentally, to discard it without any nagging concern over inconsistency. However, avoidance of error represents only one aspect of the approach. In generating and testing alternative hypotheses in any particular case, it emphasizes equally strongly the imaginative qualities of social workers. The generation of hypotheses and a sceptical approach also emphasizes precision and rigour. Social work characterized by flexibility, imagination and rigour represents a target to which practitioners may reasonably aspire.

This represents, however, a more deliberate approach to social work than that identified by England (1986). England emphasizes the ordin-

ariness of social work practice, that is that social workers are largely using their common sense, perhaps refined by training and experience, to make sense of situations. With this, in certain respects, though not in those identified by England, we may agree. Social workers, it seems, are involved in using the methodology of everyday life. However, his emphasis on hunch or intuition, on the importance of immediate judgements, considerably underrates the importance of the more cognitive and deliberative aspects of practice. Indeed, even in relation to everyday life, England's approach appears flawed: if we were simply spontaneous, acting immediately and intuitively, we would considerably increase the likelihood of 'jumping to conclusions'. In practice this may increase the likelihood and dangers of verificationism. It is surely not enough to say 'it felt right' or 'I just knew that was how they felt' (England, 1986, p. 32). In fact, if a hunch is presented as an hypothesis, this intuitive dimension represents only the first stage of an essentially retroductive process characterizing good practice. Whatever the social worker 'felt' (and this may be a poor use of language as 'thought' may frequently be a better verb), to leave matters at that would appear to entail adopting a very cavalier attitude to the possibility that their initial impressions might just be wrong.

The approaches advocated by Sheldon and others (e.g. Hoghugh, 1980) to the accumulation of knowledge appear also to be unrealistic. It appears unlikely, even were their approaches to be adopted immediately, that social workers could dispense with large areas of practice wisdom as the primary means for negotiating difficult and complex situations. However, rather than simply comparing unfavourably practice approaches to evaluating the validity of findings with those of social research, we might better spend our time systemizing and developing these practice approaches more rigorously. In this respect we might find some common ground with Sheldon. For there is a great emphasis on hypothesis development and falsification, although this is undertaken within a retroductive rather than hypothetico-deductive framework. It is by informing practice with social research processes that greater systemization may occur.

In their discussion on professions, Jamous and Peloille (1970) refer to the technicality-indetermination ratio. Technicality refers to methods which may be transmitted and mastered in terms of rules and indetermination refers to those which cannot and emphasize the individual qualities—virtualities—of the practitioners. A profession, like medicine, they think, is able to maintain and extend its control over certain crucial areas of life—health and illness—because of its success in maintaining a particular combination of technicality and indetermination in their conduct of practice. Where professional action is entirely governed

by rules, it is possible for practitioners to adopt roles which are generally routine with little discretion left to the practitioner. Where a profession operated in an area characterized predominantly by indeterminacy, there would be few rules, indicating minimal guide for practice. Medicine's success lies in the combination of rules, derived from a particular knowledge base and which emphasizes the need for professional training, and indeterminacy, which emphasizes the need for personal and good judgement in individual instances. Hence, Friedson (1970) suggests, medicine values the qualities of individuals who practise, resulting, he thinks, in a tendency to overemphasize the indeterminacy of phenomena with which they deal. 'Real medicine' is to be learned at the patient's bedside, through actual experience (Atkinson, 1977).

The trick, for any profession, is to avoid too high a degree of indeterminacy, which suggests little need for a general knowledge base, and hence education and training, at the same time avoiding too great an emphasis on technicality, which results in programmed responses, and the possibility of control by outsiders to the profession, such as managers (Weeks, 1980). The bureaucratic nature of the social work setting, together with the difficulty social workers experience at times in exercising control over the problems with which it is their function to deal, generates a constant pressure for their tasks to be routinized, through for example departmental procedures, entailing greater managerial control (Howe, 1986). The developments in care management and provision offer just such an opportunity for routinization of work and extension of managerial control. They raise questions about the unique usefulness of social work skills in relation to some client groups or tasks and the possibility that at least some areas formerly the domain of social work practice need not be performed by social workers. The development of entirely structured assessment forms (for example the Core Assessment Schedule of Devon Social Services), derived from an obscure, if any, knowledge base, and which require minimal training for use, and the employment of unqualified workers to carry out these assessment tasks, indicate the extent to which routinization and managerialism are developing.

The extent to which individual areas or aspects of practice require specific social work knowledge or skills can only be settled by reference to those particular aspects of practice. However, this can only be undertaken in the light of the particular characteristics of social work knowledge and practice. The social worker characterized by critical awareness is one who requires high levels of training enabling them to think clearly in often complex situations. They require imagination and rigour enabling them to respond reflexively to frequently uncertain situations. Being trained in this way for reflexivity, emphasizing process,

entails the development of virtualities in practitioners: it is the quality of critical awareness which is developed, and the nature of the situations which are their concern, which limit the extent to which routinization can characterize practice. Social work can only be adequately defended, and focus on the areas for which social work is required, if it is clear about the particular qualities its practitioners bring to situations. By the same token, however, the application of routinized methods to situations which are non-routine can involve 'fitting' clients into preconceived categories, without the flexibility to explore their particular circumstances. Such an approach can hardly be considered to be in the client's interests, appearing more service than needs led (however this is defined). A clear appreciation of the need amongst social workers for critical awareness is more likely to lead to realistic appraisal of social work and its contribution, while limiting the extent to which inappropriate routinization of tasks takes place.

There are, furthermore, implications for social work education. The emphasis on the need for the development of critical awareness—high level cognitive skills—is arguably associated with education rather than just training. It is appropriate that the traditional virtues of higher education, emphasizing rigour and imagination, which characterize pure as well as applied subjects, should be highly prized by social work. The tendency towards anti-intellectualism in practice noted by, for example, Sheldon (1979) and Carew (1979), is potentially very destructive in this respect. The nature of these skills, furthermore, helps explain why they are difficult to identify and why social science has often been considered relatively marginal to practice. If constant emphasis is made on a social science–social work relationship which concentrates on product, then we are looking, at least some of the time, in the wrong place for our knowledge base.

There exists, furthermore, in some quarters (Sibeon, 1990) a suspicion that there is less commitment to these aspects of social work learning emphasizing rigour, imagination and scepticism in the Dip.S.W. curriculum than might be desirable. Despite the advance represented by a minimum of two years in higher education to achieve a qualification, we may question whether this is sufficient adequately to develop critical awareness. Social work, it is arguable, should as a minimum be a degree level subject, not only because of the applied 'product' nature of its knowledge base, but because also of its 'process' nature. It is, paradoxically, because of the limits to the 'product' knowledge available—the kind of knowledge which justifies long and high level training for traditional professions such as medicine—that a long training is required for social work. However, a particularly strong focus, in this case, would be required on the processes of rigorous knowledge

accumulation. It may well be that, in developing the systematic practitioner, we can learn from focusing, in the curriculum, on the processes of social research. The quality of imagination, the capacity for rigour and the ability to question both your conclusions and the way you go about reaching them would appear to be qualities which should be required of social workers even at basic qualifying levels.

Social work has at times appeared less than convincing in identifying a clear and distinct knowledge base, and has seemed to many to be an activity which any reasonably competent person might carry out. It is, perhaps, more than ever important to identify clearly the kinds of knowledge and virtualities required for social work. This essay is presented as a contribution to this process.

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