Professional Boundaries in Social Work:
A Qualitative Study.

Prepared by PJ Parker. 1-2 Munton Road, London SE17 1PR / WITNESS. 32-36 Loman Street, London SE1 0EH

Table of contents

Professional Boundaries in Social Work. Qualitative Study.

Parker

1-2 Munton Road

London SE17 1PR

parker@rebelsincontrol.com

WITNESS

32-36 Loman Street

London SE1 0EH

info@professionalboundaries.org.uk

Introduction

This is the final report on a small scale qualitative study, convened in two phases among a panel of people who currently use social services or who have used services. The study took place at WITNESS' offices in London, March to May 2009. Each phase comprised a series of depth interviews of 70 minutes duration, conducted individually with respondents, moderated by Patrick Parker and supported by Lynn Hiltz from WITNESS. WITNESS is a charity concerned with preventing breaches of professional client relationships. It provides support to people reporting abuse by health or social care workers, training on professional boundaries for practitioners and works to influence national policy developments.

The sample comprised a mix of seven male and female respondents, with a range of ages and social backgrounds. WITNESS recruited respondents to the study from a pool of people who had received support from WITNESS in the past and from voluntary sector and service user networks. The sample was split between respondents who have used the services of social workers without any boundary issues arising and respondents who have used the services of social workers where the social worker violated the professional boundary through sexual exploitation (sometimes designated below as 'survivors'). It was not within the scope of this study to consider the individual details of such experiences, for which this research protocol would not be appropriate. Instead the aim was to explore actual and hypothetical scenarios *(Appendix 3: P.44)* involving encounters with a social worker, in order to elicit feedback on where users of services feel professional boundaries should lie and why. A detailed discussion guide is given in the appendix to this report *(Appendix 2: P.41)*.

Whilst a focus group setting was initially considered for this study, it was felt that a single depth interview approach was much better suited to the sensitivity of the material and to maintain individual confidentiality.

Research methodology for Phase 1

During Phase 1, all respondents were interviewed singly by moderator Patrick Parker according to a discussion guide given in the appendix to this report *(Appendix 2: P.41)*. All interviews were conducted in the presence of Lynn Hiltz from WITNESS, who was there to provide support, primarily to respondents (but also to the moderator).

Great care was taken by both team members to brief every respondent taking part, to ensure that they understood they could take "time out" at any time, did not have to go into subjects they preferred not to discuss, and were comfortable and relaxed during the session. Time was also taken to explain the detailed purpose and structure of the research, the intended audiences, and how answers were likely to be used. The session was structured according to a detailed discussion guide *(Appendix 2: P.41)*, but was informal in style and tone, and also allowed for open-ended discussion.

Interviews were recorded for note-taking purposes, following which the recordings were destroyed to preserve anonymity and in accordance with the undertakings given to respondents during the initial briefing section of the interview.

Respondent feedback was sifted into recurrent themes and an interim report was created which set out the principal themes that emerged under a variety of headings, illustrating each of these with relevant, verbatim respondent quotations.

Because of the small size of the sample recruited for this exploratory study, no attempt was made to weight the responses or themes, or to extrapolate the findings to a national picture, other than to indicate in which areas many respondents had shared a similar experience, said similar things and wanted similar changes to occur in the relationship between service users and providers.

Rather the intention of the report was to highlight areas that could form the basis of further research and investigation (to "find out what we need to find out" either qualitatively or quantitatively) and, as has been said above, to add greater colour to the picture of user experience, for research commissioners.

This said, despite the variety of life stage and background within the sample, there was remarkable consistency in respondent feedback as can be observed below in the Phase 1 findings.

This interim report was circulated among both research commissioners and research participants in preparation for Phase 2.

3.

Research methodology for Phase 2

A second phase of interviews took place six weeks after the creation of the interim report among the majority of respondents from Phase 1. Two initial participants could not attend Phase 2.

Prior to being re-interviewed, all respondents returning to research were given a copy of the interim report to read. A short pro-forma document *(Appendix 4: P.46)* was also supplied, solely to help respondents collate their responses and feelings about the interim report.

The interviews for Phase 2 followed identical principles to the first phase in that respondents were supported by Lynn Hiltz from WITNESS, and given a detailed initial briefing to ensure they understood all aspects of the research methodology.

Again the discussions were open ended in nature allowing us to cover the pro-forma responses *(Appendix 4: P.46)* and to discuss more generally the themes that were highlighted - in fact to allow respondents to pick out whatever was most important in the report to them personally.

Because of the sensitivity of the topics for discussion, it had not been possible to conduct Phase 1 in a group setting. Distributing a report that contained verbatim feedback which was anonymised allowed us to share feedback from users of services among all participants in a safe way. Interviews for Phase 2 were recorded for note-taking and then destroyed, as had been done in Phase 1.

During phase 2, time was also given over to discussing with respondents key slides from the presentation Professional Boundaries commissioned by the General Social Care Council (GSCC) *(Appendix 5: P.47)* which has been produced in parallel with this study. Key slides were used to probe the issue of how a professional boundary might be drawn, described and acted upon in training or oversight contexts.

Following the Phase 2 interviews, a final report was produced summarising the findings of Phase 2.

Research objectives

The objectives for Phase 1 were as follows:

- To elicit from a variety of people who are using or have used services, their views on what constitutes boundary crossings and boundary violations and what are safe boundaries.

Within this:

- To elicit feedback on a number of hypothetical scenarios *(Appendix 3: P.44)*, with a view to determining where on the professional boundary each would lie for both "survivors" and "users of services" and to investigate where, if any, different views on this might lie.

- Through this feedback to create an interim report - for WITNESS, regulatory bodies and other agencies who administer, train and monitor the work of social workers - that gave a more detailed picture of service user experience and awareness of professional boundary violation as well as good professional boundaries.

In Phase 2, by reviewing the interim report with respondents we were looking to cover the following research objectives:

- Elicit respondent reactions to our Phase 1 findings.
- Allow respondents to re-appraise the principal themes they had discussed in Phase 1.
- Examine the respondent experience of Phase 1.
- From this, to provide guidance for future research phases.
- Create a pool of ideas for improvements to services generated by respondents.
- Discuss the implications of the research for social worker training and oversight.

Phase 1 findings: Service users' perceptions of social workers

Across this (small scale) research sample, there was a general acceptance and understanding that the public view of the social work profession can be informed by stereotypes and is heavily influenced by negative media coverage, particularly in recent weeks.

> *"I think the public perception is quite negative. Incompetency has featured on the radio and in the papers quite a lot. I think they are highlighting that a lot more."*

However, direct experience can create a more nuanced view.

> *"The general public would probably have a poor opinion because of the press coverage, and would probably say - they are all rubbish and how can they sleep at night? But people who understand more of what they do might have a better opinion."*

In fact nearly all respondents interviewed in this study had some positive experiences of working with social workers to recount. It appeared that, where the relationship worked well, and was delivered to users of services in a professional way, it was highly valued and productive for people across a number of dimensions.

> *"Extremely useful. Very good indeed. She has reduced my level of anxiety enormously."*

> *"I think they generally do a good job in horrendous circumstances. The one I had was a very decent person."*

> *"In theory they can help you access services and get help."*

Phase 1: Beginning the service user / social worker relationship

Several respondents reported that a social worker had appeared to enter their lives uninvited and seemingly out of the blue. This was a consistent theme in respondent feedback.

> *"I was allocated a social worker but I never quite understood how."*

> *"She appeared from nowhere. I didn't know how she knew me, or where she came from."*

> *"I just didn't know where on earth this person was from or where he worked."*

> *"You are allocated this person. You know nothing about them. There is nothing to say what they do, what they should do. I don't know what actually they are supposed to do, and I've been ten years with it."*

Consequently for several respondents, the relationship began in a hazy way which could be disorienting. Across our research sample, the introduction to a social worker was inconsistent. Formal information about the structure of the relationship was either in short supply or totally absent. There was no induction meeting, no written information. Sometimes an informal (handwritten) note had been delivered, or the introduction was verbal only.

Phase 1: The role of the social worker within mental health teams

Discussion of the remit of the social worker, especially in the area of mental health, drew out a lack of clarity. Respondents found it very difficult to describe precisely what they felt should be the proper role of the social worker in the context of mental health.

Because the role of the social worker in their lives had never been formally defined for them by introductory literature or at an induction meeting, respondents could not precisely map out a social worker's responsibilities in this area.

In particular, concerns were voiced about the instances in which there had been a blurring of boundaries between practical support given on a day to day basis and medical intervention or advice across the longer term (whether or not take to medication) during a service user's recovery from illness.

Several respondents felt strongly that they did not want social workers to intervene or comment on their medication at all. This, it was felt, had violated their personal boundary and was intruding into a relationship with their GP which they wished to remain private and confidential.

> *"What is the role of a social worker in a mental health environment? I don't know. It's a hard question to answer because I don't know how they are trained."*

> *"I don't know what social workers' therapeutic role is. What I found inappropriate was when a social worker comes to me and asks me - have I any side effects with my medication? I don't know what my side effects might be and as far as I'm aware social workers are not trained in medicines or their side effects."*

> *"She insists I am medicated even though my GP says there is no evidence of psychotic behaviour. She is insisting on drugs I neither need nor want."*

Phase 1: Professional boundaries of the social worker

Our respondents were very clear about what constitutes professionalism - which they saw as the key to engendering feelings of safety and confidence. The respondents said that professionalism encompasses many strands of communication and behaviour. Below are the areas focused on by respondents, with their views summarised in parenthesis:

- Style of dress
  (informal is fine but not scruffy).

- Tone of voice
  (not condescending but appropriate to my age and intelligence).

- Structure of the relationship
  (formalised and clear from the outset).

- Choice of vocabulary
  (words that are warm but safe and unambiguous).

- Asking appropriate questions
  (relevant to my circumstances).

- Setting, context, and occasion of information gathering
  (in a private place, at the right time for me).

- Not overclaiming
  (it is better to underpromise and overdeliver).

- Regular reporting
  (tell me what's happening, even if nothing is happening).

- Maintaining confidentiality
  (communicate to me personally and privately always).

The principal issues for people who use services under these themes are dealt with in detail below.

Phase 1: Maintaining professionalism while adapting to the needs of the user

The most complex issue, as respondents saw it, was how to engender empathy and warmth, while retaining a clear professional boundary. This was seen as the most desirable skill set - and it was acknowledged that this could be a difficult thing to achieve.

Therefore respondents felt that this was a skill set that has to be learned and practised but just as important was that the delivery of these skills to service users should be regularly monitored (sometimes in situ) and refreshed (by refresher training), in order to maintain both relevancy and appropriateness to service users, as well as to ensure that social workers do not cross professional boundaries.

Crucially, a one-size-fits-all approach was rejected. There was, it was felt, no substitute for knowing a user of services and his/her circumstances well and developing a tone of voice and level of response that was appropriate to an individual user of services, but always within a clear set of boundaries.

> *"I think it's a really hard thing to do because you might be creating social workers that behave like robots. But I think it's important for them to show empathy. That is difficult, even if somebody is a friend, it can be difficult to show empathy."*

Again it was acknowledged that there can be a difficult balance to be struck and that sometimes "the system" and too rigid adherence to a set of protocols or guidelines may be at fault. Guidelines were important - to set a structure - but were guides, not laws.

> *"I think it's led by the system. How does going through a fifteen section ring binder and ticking boxes assist me? "*

> *"A lot of the poor ones treat it as a tick box exercise. Because the care plan says you must see the person once a week, they come along, tick a box, ask a few questions and go away."*

> *"The system is a disaster because it presupposes it is dealing with people who have capabilities equivalent to it."*

> *"It's important to make known this is the way things should be done but it shouldn't be a tablet of stone. You can't impose a rigid model on everybody. You're back to imposition and depersonalisation."*

Phase 1: Social workers as part of a team

There was some discussion of how the social worker might fit into and liaise with other agencies engaged with assisting users of services. According to respondent feedback, this does not always work well. While it was felt essential that confidentiality should be maintained, nevertheless it was felt there could be better networking and sharing of information, with the crucial proviso that consent be given to share relevant information - on relevant occasions. In fact respondents reported that responsibility, and therefore delivery of service, is often fragmented and doesn't pay attention to the full range of service user needs.

> *"The mental health worker wasn't interested in how my children were coping at this time, and neither were the social workers dealing with my daughter, one bit interested in me. It never came together. They don't want to have anything to do with the bits they're not dealing with. They're meant to be helping people but they're not networking enough to help the family, just the individuals in it."*

> *"They say they have multi-disciplinary teams. I think it works well in the hospital environment. I don't think it works well in the community."*

> *"My experience recently is it seems to be not a community mental health team but a series of community health individuals".*

> *"I am lucky now that I have moved from the community team into the assertive outreach team. They actually work as a team and you can see the big difference. The quality of service is much better. They seem to talk. They know you. They know your problem. They are not afraid to say I will get someone else to deal with that because they are better equipped to help."*

Once again discussion of team working brought out the ways in which the role of the social worker lacked definition for the user of services and could lead to boundary crossing. Without a clear definition, adequate oversight could not take place.

> *"You need to clearly define the role of the social worker within these teams. For the service users. If it's not defined for service users, how can it be defined for the management? How can it be defined for the monitoring?"*

Phase 1: Breaches of confidentiality

This was a persistent theme in respondent feedback during this study. Nearly all our respondents could cite examples where their confidentiality had been breached, the most common instances being informal correspondence, greeting a person using services in public settings and, in one example, calling loudly through the letterbox during the day on a public street, without first ascertaining who else beyond the person using services might be inside.

It is perhaps an obvious consequence of the apparent lack of a formal structure at the beginning of the service user / social worker relationship (which is dealt with below) that breaches of confidentiality can occur. This was the most frequently cited example of ways in which boundaries were crossed.

> *"She dropped a note through my door, a note without any envelope saying - I am your new social worker - in very scrawly handwriting. And this was dropped through the door of a communal block of flats. And she didn't even fold it. So I don't know how many people had read it. I was really threatened by that - the fact that my neighbours knew."*

> *"The first time, he knocked at the wrong address and left a note for me, for the occupant there. No apology at all."*

> *"She called through the letterbox - I have come with someone from the community mental health team. And to come unannounced. I wasn't dressed."*

> *"I was asked about menstruation on a train, a public train, by one of them. Even if it was a doctor you would still complain because it was a train!"*

Phase 1: Formalising the service user / social worker relationship

While respondents acknowledged that during times of mental illness they might be unable to retain or understand facts about the relationship, they felt it essential that core information should be given consistently in all cases and should be available for the use of family members or carers surrounding the user of services. There was much practical advice given about how this could be delivered.

> *"It took months before I realised it was a mental health worker I was seeing. I didn't know who I was seeing really, or why. Maybe a manager should have come with him the first time. I didn't even know where he was based. I had gone to the GP first. So maybe the GP should have explained, why I was being put in touch with him, and what his role would be. A total and utter lack of communication."*

> *"When someone is going to be assigned a social worker, some sort of letter or structure written down introducing the person, where the person works, what the appointment times will be, what to do in an emergency between those appointments, how long is the duration, whether you will have reviews. Just a letter headed paper to let you know where this person has come from, where they work."*

> *"I think there should be some simple pamphlet for service users and carers. Don't forget carers in this report. The carers, the family have got to know what the role is. It should be explained and* [there should be] *a little booklet to take away. "*

13.

Phase 1: Losing control of the service user / social worker relationship

Because of this initial lack of clarity and consistency, some respondents reported feelings of loss of control at an early stage in their relationship. This was quite frightening for many respondents, at a time of already heightened anxiety, loss or illness.

Service users were unsure of their rights or how to find out what their rights were because they were not given any official information. There was no leaflet to consult, no Charter for users of services, and very often no letterhead detailing a central office or management structure.

It was felt that social workers can have considerable power. Because of the nature of the service user / social worker relationship, there is an uneven information flow. Social workers must, of necessity, know a fair amount about people who use their services.

> *"A social worker is party to personal information that can make for an unequal footing."*

The lack of information on the service user side is significantly disempowering by contrast. Again this can be very frightening for people using services who feel acutely aware that they must tread carefully and say or do "the right thing" if they are to avoid adding further complications to their own lives, particularly during their initial encounter with the social worker.

> *"My initial experience was very negative - quite frightening really."*

> *"If you get on the wrong side of them you can get yourself into a lot of trouble."*

> *"I was aware that the answers I was giving would affect my son."*

> *"People that deal with social workers are usually vulnerable."*

> *"I wasn't sure what my rights were. I wasn't sure if I had to let these people in."*

> *"To have such a powerful job, to pop in and out of people's houses whenever he liked. I don't know whether those appointments were ever logged, to this day. Did his manager know that he was coming?"*

> *[The social worker] "... not being professional enough when... [they are] ....coming into your house, can create a bigger problem than was already there."*

Phase 1: Making choices within the service user / social worker relationship

Discussion of this aspect of the relationship drew out a contrast with the GP / patient relationship which many respondents felt was the closest available comparison. A choice of GP is available, and because everyone has a GP there is plenty of anecdotal information to draw on about how this relationship should work. Having a social worker is a much less common experience and so awareness of how this should be conducted is far lower.

> *"It's not a relationship of choice. They land on you. It should be one of choice. They should be able to choose in the same way they can choose to go the GP."*

> *"I think there are certain circumstances, it would be nice to be able to choose* [the gender of your social worker]*. With other professions you have a choice."*

For most, gender was not a significant issue, but there was an understanding that this could sometimes be important, depending on the past history of the service user in question. In addition, the element of choice was important for some of our interviewees who wanted a social worker who was at a similar life stage. It was felt there should be some attempt to match social worker to the person using services in some way and that there should not be large disparities. The resultant mismatch had sometimes created anxiety or anger because the social worker had adopted an inappropriate style or tone of voice.

> *"I felt very uneasy when I had a social worker who was much younger than me, and had no life experiences to draw on, and simply couldn't understand what I was saying."*

> *"Someone half my age. She kept calling me a wee girl. Who are you calling a wee girl? I'm 50 years old."*

Phase 1: Improving the service user / social worker relationship

It is clear that a lack of clarity at the outset has the potential to create real problems and anxieties for people using services and their carers. This was frequently reported by respondents taking part in this study. Critically, the lack of a clear and formal structure at the inception of the service user / social worker relationship can create a space where professional boundary crossing may occur.

> *"A lot needs to be clarified, especially when somebody is mentally ill and it's in your own home. You don't even know if you're allowed to say you don't want someone to hug me. I suppose it's so easy for social workers to do if they can go to people's houses and not have management checks."*

There were a number of ways in which respondents felt that these difficulties should be addressed and improved, which would reduce feelings of anxiety, and restrict the potential for boundary crossing:

- Structured initial meeting.
- Structured induction literature.
- Information for carers, families and other people providing support.
- Delivery of the relationship in a consistent way across all users of services.
- An element of choice and better match between social worker and the person using services.
- Communication to people using services and their carers that management checks are taking place.

In addition, discussion of this topic elicited the following features that respondents felt were essential to improving the quality of the service they receive and the professionalism of the encounter with the social worker:

- Precise, detailed and accurate recording of the circumstances of the person using services.
- A parallel statement from the person using services to be recorded in parallel at induction.
- A structured setting for individual users of services to feed back their views on and experiences of services.

Phase 1: Accurate recording

For some respondents the social worker was perceived as a powerful person entering their lives. For service users in crisis, a great deal of practical and emotional security may hinge on answering "correctly".

> *"The social worker is there to make some kind of judgement and a lot can flow from that."*

Great stress was laid on the requirement to record accurately, on the basis that all individuals will vary. It was felt that teaching how to record accurately should be a vital component of a social worker's training. There was much criticism laid on the fact that many answers cannot be recorded in an open-ended way, but rather must conform to the requirements of a questionnaire. Why, it was asked, could not the questionnaire be supplemented by open-ended answers, and a statement from the person using services or their carer that formed an additional component of any assessment or application?

> *"Don't make assumptions and consider the bigger picture. Treat everybody as a unique individual."*

> *"I can see that we don't have conventional circumstances but she wanted to pigeonhole me. I wasn't being evasive. I was just feeling very vulnerable at that stage."*

> *"The information exchange. They way they record and then transmit that information to other people. That is a key component of their job. If at any stage they get that wrong, and not record absolutely accurately, not skew it so it looks as if they are OK, or reads better, so that everybody is clear and it can't be misinterpreted."*

> *"I thought X, she thought Y and then recorded Z. "*

Phase 1: Asking questions

It was understood that to make an assessment a social worker must ask often very personal questions, and on many occasions within an intimate setting (the home of the person using services). Often this was felt to be intrusive or sometimes prurient. Perhaps the lack of a clear definition of the role of a social worker for the user, can intensify this feeling. Once again this stage of the encounter has the potential to heighten existing anxieties and create fear and mistrust.

Therefore it was felt to be extremely important for people using services to understand why questions were being asked and what might follow from the answers. Explaining the context and rationale for key questions, it was felt, would set a clear boundary apparent to the service user and create feelings of safety. Critically, the questions asked should be related to deliverables, while at the same time there should be no sense of overclaim.

> *"You have got to ask the questions to do your job, but you have to understand the context and* [it has to be related to] *something that is moving forward."*
>
> *"I think at times the questions can be interfering and they can seem to be nosey for no apparent reason. If the question is a legitimate question, to find out a particular area so you can provide support and assistance that's no problem. But if the question is just interfering and is not explained and there is no support to follow up the question then that is totally inappropriate and you are giving the person a false sense of what is going to happen and what can be delivered."*

Phase 1: Delivering the service

Of great importance to respondents in this study was the delivery of service against the level of expectation raised.

> *"A lot of false hopes and false promises. And then not following it through. Not even bothering to phone you to tell you it hasn't been followed through and leaving you in limbo."*

> *"To leave someone waiting for a phone call can be very stressful."*

Several respondents felt that it was of great importance not to raise expectations too high about what could be delivered, rather it was felt better to under-promise and over-deliver.

In parallel with this, respondents wanted regular reporting at promised times.

> *"Even if nothing is happening, just phone me and tell me that nothing is happening."*

Phase 1: Feedback from people who use services

Many respondents described a situation in which there are no channels to feed back their experience of the relationship. Meanwhile they felt they were locked into a relationship with a person who has a significant amount of power: power over how their circumstances are recorded, described, and reported to a variety of third parties.

> *"User feedback. Make your own kind of statement. Once a report has been made it's all a fait accompli."*

It was felt by some respondents that service user feedback was an important component of social worker accountability, which it was felt was lacking, partly because of the working structure. Perhaps service user feedback would in some way compensate for this or fill the gap that the structure had created.

> *"Social workers are seconded by the local authority to the Partnership Trust. But it is run at arms length from the local authority. So they are accountable to an organisation that doesn't manage them."*

Phase 1: Crossing boundaries

All respondents in this study were exposed to a number of different hypothetical scenarios *(Appendix 3: P.44)* describing encounters with social workers which ranged from safe and professional statements or behaviour to very clear boundary crossing. However there were many scenarios that lay somewhere between these two. Respondents were asked to map all of the scenarios (which were randomised for each interview) on a simple axis - whether or not they felt that a professional boundary had been crossed - and were asked in each case to describe their reasons why.

In doing this exercise, there were some differences in the map positions given for many of the more ambiguous scenarios, between users and "survivors" (between those who had, and those who had not experienced boundary violations). "Survivors" were much more clearly against nearly all forms of deliberate personal disclosure and physical contact, though they accepted that on very rare occasions, inadvertent personal disclosure might be unavoidable. Survivors had gained a retrospective understanding that personal disclosure in particular had been the beginning of a path to increasing disclosure and intimacy - what was sometimes described as the "slippery slope".

> *"Possibly an occasional one-off comment might be ok, but you are there to help other people. You should keep everything personal to yourself."*

> *"I don't think you should self-disclose. You shouldn't talk about yourself. You don't reveal things about yourself personally in a professional situation."*

In assessing the hypothetical scenarios with which they were presented, these respondents were able to offer much practical advice as to how concepts should be framed for users of services in ways that created feelings of safety. Respondents also suggested ways in which information for users should be presented to clearly demonstrate how these actions or statements were may be surrounded by safeguards. For example: when giving a user a mobile phone number to use: one "survivor" felt that a social worker should say

> *"'I am allowed to give this number out. This is a service that we offer.' Or a card with a number printed on it, to verify it for people. Giving out a mobile phone number would have to be explained."*

Phase 1: Crossing boundaries (continued)

For service users who had not experienced boundary violations by their social worker this was sometimes a difficult exercise. The lack of a clear framework, set up at the outset of the service user / social worker relationship meant that respondents had no clear benchmarks by which to assess the more difficult and ambiguous scenarios.

In these more complex instances they felt that they would rely on an intuitive sense of the social worker - what actions had come before and what came after. These were the private gauges they relied on to assess whether a boundary had been crossed.

Alternatively when confronted with the complex hypothetical scenarios, both types of respondent felt that a public setting would neutralise the more ambiguous actions or statements they were invited to consider.

> *"It's ok to hug me in public but not in private."*

> *"Have somebody with them at all times, somebody you can trust, a friend. Someone you feel comfortable with and will take on board information. You are too vulnerable on your own. Someone on their own, with their brain not working properly, with somebody else controlling, it's too much power for them to have over somebody, I feel."*

> *"There was nobody to say whether what was happening was right. I still don't know."*

> *"Is it right that vulnerable people should be met in their own homes?"*

Phase 1: Vocabulary that creates feelings of safety

Among all respondents, the appraisal and interpretation of the hypothetical scenarios *(Appendix 3: P.44)* was carefully considered, detailed and sophisticated, despite the fact that ongoing service users - versus "survivors" - had few benchmarks to rely on.

This exercise drew out the ways in which the choice of language, as well as actions, is absolutely crucial to signalling appropriate and professional values and ensuring that boundaries are not crossed.

Selection of specific vocabulary appeared to demonstrate verbally to service users that a professional boundary was being maintained. The appropriate vocabulary need not be overtly formal to create a reassuring psychological space for users. Instead, a common response to our scenarios was:

> *"They could think of a better word. A safer word."*

Many of the respondents found it easy to generate safer expressions and idioms to the ones articulated in the scenarios where they felt there was a boundary crossing.

> *"If you said to somebody, 'you look smart' or 'that is a nice coat' - that would be ok. But to say 'you look lovely' is too much of a comment on what you look like. If I was a social worker I would be careful about saying that to a client."*

> [They should say] *"'You look very well today', not 'you look lovely' which has romantic overtones."*

> *"The word 'kind' is a very neutral and positive thing to say but 'my wife doesn't understand me' is the slippery slope part of the sentence."*

> *"It's the word 'always' that is wrong in the sentence 'I will always be there for you'."*

> *"Again I've got a problem with the word 'amazing'. It's similar to 'lovely'. There are a lot of other words they could choose which don't have the potential for ambiguity. A social worker could claim they were just trying to boost your self esteem. But there are other words that they could use that don't have that ambiguity. They could say 'you're intelligent'."*

23.

Phase 1: Actions that create feelings of safety

Exploration of the hypothetical scenarios *(Appendix 3: P.44)* that involved physical contact brought out the feeling that there was a different interpretation to private versus public behaviour.

> *"I think a hug is over the line. A pat on the arm is ok. I don't really like hugs anyway but I think a hug is a step too far. Not rubbing my arm. But patting. I think it's the motivation behind what they do, and the context in which it takes place. A pat on the arm could be completely appropriate in a particular context. But if it's a way of getting closer to them by having some physical contact, then it's a slippery slope."*

> *"I think a handshake creates a degree of safety. Anything that creates and enhances a sense of safety, or indicates a sense of safety, is going to strengthen boundaries and strengthen people's awareness of them. For me a handshake is often a mark of respect for a person. If a social worker didn't bother to shake my hand, I would be a bit put out. Is that because I went to a lot of business meetings? If you don't shake someone's hand, it's an insult. So I think shaking hands is probably mandatory. Unless there might be cultural reasons why."*

Phase 1: Why do people who use services feel professional boundaries are important?

One respondent who had experienced a boundary violation by their social worker explained that the clear definition of boundaries had significance for both users of services and social workers. Her closing remarks during her interview capture much of the ground covered above in this report and provides an excellent summary of the impact of boundary violation.

> *"Social workers have to really understand the potential for long term damage of serious boundary violations, how it can shatter someone's sense of themselves, put a shadow over the rest of their life and in extreme cases cause someone to kill themselves. That's how serious it is.*
>
> *Some social workers, like the one I had, are deliberately predatory people. But there are probably lots of other social workers who find themselves sliding down that slippery slope without realising how they came there. It's incredibly important to understand how they get themselves into these situations of blurring the boundaries. They might have good intentions and despite themselves, find themselves in that situation.*
>
> *So they really have to pay a lot of attention to this sort of thing. Unless you understand why these boundaries are there, they could find themselves involved in a difficult situation and not know how to cope.*
>
> *Or find they are inadvertently doing something which creates a response in the client, gives the client the wrong idea which causes pain and distress to the client. They have to be aware of the serious consequences of the extreme violations, but also the ones that are just teetering over the edge, the slippery slope. Because they don't know how the client is going to respond to that."*

Phase 1: Other research commissioned by the GSCC

In parallel with the creation of our interim report, another phase of research was devised by Sheffield Hallam University Centre for Health and Social Care Research. This research was commissioned in early 2009 by the General Social Care Council. It aims to explore how social workers access guidance to professional boundary issues and what guidance there is for social workers in the United Kingdom.

A small number of slides from this presentation were also shown to respondents during the Phase 2 interviews, in particular the recommendations made *(Appendix 5: P.47)* and the diagrams variously describing boundary violations as a line between Right and Wrong *(Appendix 5: P.48)* or as overlapping circles *(Appendix 5: P.49)*. While there was some in-principle agreement with the recommendations, respondents wanted all recommendations related more concretely to real life examples - what was the direct implication of each recommendation in an example context relevant to the real lives of users of services.

The two sets of diagrams spoke more directly to respondents who agreed that this threw up the central problem of describing or teaching the complexities of boundary violations - but they felt that these diagrams raised more questions than they answered. It was agreed by some that a too rigid an approach may adversely affect the person using services.

> *"With a tick box approach you can never cover any scenario and it stifles innovation."*

> *"Some issues are very clearly wrong such as sexual contact - others will vary by client / social worker relationship etc".*

Other respondents objected to the representation of the boundary violation as a series of overlapping areas *(Appendix 5: P.49)*. Some questioned the proportionality of this approach - because it didn't put the person using services in a primary position.

> *"I think it's impossible - how do you set boundaries if it's not a boundary, if it's semi-permeable."*

> *"The agency part doesn't really exist - you can't get hold of these people."*

It was felt that testimony and scenario-based training, against a basic set of principles, answered some of the issues raised by the diagrams, which were felt to be too general. Significantly, as above, respondents wanted always to factor in independent voices.

> *"The best way is to have the key principles, train by scenario. When they are out there on training they are supervised correctly, and when they are qualified they are supervised by line managers, and this is independently checked and quality assured."*

Phase 2 findings: Experiences of taking part in the study

All respondents reported positive experiences of taking part. Although the discussion guide and research stimulus were equalised across all interviews according to standard research protocols, the structure of the research also allowed for open-ended discussion *in combination with* a heavily structured approach, and this worked well for all respondents.

For some, this drew a contrast with the information gathering phases of their interaction with social services - where some had complained that "tick boxes" only catered to a limited range of possible answers that may not adequately or accurately describe their feelings and circumstances. There was a generalised view that being able to talk in an open ended way, as well to a specific discussion guide, ensures that nothing is missed. In addition, talking is preferable to supplying written answers.

> *"I expected it to be flip-charts and multiple choice questions and a bit dry. I enjoyed the fact it was interactive. I liked the exercises; it was interesting and enjoyable to do."*

> *"I much preferred it to having to write my answers. I would spend hours and hours trying to get the words right. I would get stuck in a loop."*

> *"An open meeting - you felt you were listened to. And it's going into a study that people will actually read."*

> *"I was glad that what I had experienced and what I had said about my experience was faithfully reported. Reporting it truthfully. What I had said was put down in black and white and has gone straight to the regulator."*

Phase 2: Experiences of taking part in the study (continued)

As can be seen above, intrinsic to eliciting rich feedback from respondents is a detailed explanation of how the answers will be used and to whom they will have relevance once they have been recorded. Having read their own views, and those of other participants, respondents were keen to know:

> *"How is the report going to be implemented? Will it be discussed?"*

In addition, the opportunity for respondents to review the interim findings and to identify which areas they would like to see given special emphasis, acted as a check on any conclusions the researcher may wish to draw. One respondent drew such a parallel with her initial interview by a social worker.

> *"If you are at cross-purposes from the start, it can be very difficult to get past that."*

One respondent indicated that taking part in a study of this kind could form a small component of recovery.

> *"I felt a bit peaceful afterwards because I had done something that might help. It made me feel very good about myself that I had travelled to London, found where to go, and had sat there and answered the questions."*

Another laid stress on the fact that the study was focussed on the experiences of adults within the social services context and felt that this was an under-reported area.

> *"When you read the newspapers, there is practically nothing about the experiences of adults in relation to social services. The focus is on children such as Baby P and witch-hunting. It is just crazed media hype. I think it's important that research like this is done which highlights what is really going on."*

A common theme in respondent feedback was a feeling of relief; either that the report was faithful to what had been voiced during the interviews, or relief that "something was finally happening".

> *"I felt relief that somebody was doing some research. Because I feel that people like myself, people using social services and having mental health issues, our voices are hardly ever heard. So it's a great relief to have the quotes from the people you interviewed. It's quite nice to see your own quotes written down."*

Phase 2: Feelings on reading the interim report

For some, reading the report was partly a healing experience in that testimony had been faithfully reproduced, and there was a place to put unpleasant feelings that had some meaning and ongoing function.

It appeared that critical to engendering this feeling is the accuracy of recording, and no attempt to translate what users are saying into technical or agency language or concepts. This highlights the considerable power of testimony across several dimensions, as is described below.

> *"I found that it was very therapeutic. I feel that something positive and healing is coming out of something that was negative and destructive. You have made me feel that my voice is important, whereas it used to be mute. That is what I feel. It's very empowering."*

> *"I felt that it was really balanced and honest. And understandable to me. It would be clear to people reading it. It wasn't in fancy language and didn't have a lot of jargon in it. Anyone could understand it."*

Phase 2: The power of testimony

Allowing respondents to review the findings acted as something of a cross-check by a peer-review group. Individual respondents expressed surprise that experiences were shared by others in the study, having felt at times that they were alone in wishing to complain, or experiencing stressful aspects of the service user / social worker relationship. Respondents were pleased to have their own interpretations confirmed by parallel testimony and, in turn, to confirm the testimony of others.

> *"Any time I read anything that is by some of the other survivors, I thought 'Oh that is so like what happened to me'."*

> *"I'm not alone with the problems I have encountered - I have seen that by talking to other service users - although only in my own locality."*

Reading testimony has the power to alleviate feelings of guilt.

> *"It makes me think it wasn't my fault and someone else shared the same experience. It makes me feel less guilty about reporting the social worker. Because I still do have a bit of guilt about that. It confirms that I don't have to feel like that."*

Reading testimony has the power to reduce feelings of isolation.

> *"I was relieved to see that other people had brought up the same issues. And that these issues might be addressed. I have sometimes felt like a freak who can't cope with the system."*

> *"I recognised something in everything. Not just in my own words."*

Reading testimony has the power to engender feelings of involvement.

> *"I was glad to have the chance to talk about my experiences. I have never had the opportunity to talk about that situation. Nobody has ever spoken to me about it. It was nice to be able to contribute to something that will help people in the future. And help social workers understand their power and their potential for good and harm."*

Reading testimony has the power to create re-appraisal and self-reflection.

> *"There were a couple of things in there I had never thought of before, and every time I read them, it means a lot to me."*

Phase 2: Possible uses of testimony

Discussion of the verbatim nature of the content of the report led several respondents to suggest that testimony could form a powerful component of social worker training.

It was felt that communicating the importance of the issues surrounding boundary violation within training scenarios or to those overseeing social workers was extremely complex because individual user circumstances vary so greatly - and because boundary violation can occur on many axes, and sometimes unintentionally.

"Codes of conduct" to be learnt in isolation could lack saliency and meaning unless directly related to real life examples. Genuine testimony could, it was felt, be used as illustrative material, to flesh out the teaching of general principles.

> *"Verbatim quotes - gives it the ring of truth. It's about real people and real things. It brings it alive."*

> *"People who have been through this - could there be a recording of their testimony during the training of the social workers, to make it real?"*

> *"Taking somebody's story and making it real by hearing their voice or actually seeing them. Sometimes you switch off during lots of words or too much PowerPoint."*

> *"Maybe even interviewing people who have been victims of boundary violation. People who would be willing to go and talk face to face with a group of social workers. Interview tapes would be brilliant."*

Phase 2: Issues that respondents wished to emphasise

Having reviewed the interim report and research findings, naturally most respondents returned to the second phase wishing to highlight to us those areas that were of specific personal interest. However there were keys areas of commonality. Among quite wide ranging discussions it emerged that, within this report, the issues of greatest significance to respondents were:

1. Adding structure to the relationship between service user and social worker.
2. Addressing the power imbalance between service user and social worker.
3. Clarifying the role of the social worker within the mental health team.

It was stressed that none of these should be considered substitutes for, but in fact must all be supported by adequate supervision and independent oversight.

Phase 2: Issues that respondents wished to emphasise

1. Adding structure

The lack of structure at the onset of the service user / social worker relationship was dealt with in detail within the Phase 1 findings circulated to them, and much time was given over to talking through this issue and the degree to which experiences of this kind had engendered feelings of loss of control and anxiety.

All respondents returning to the study felt that the inception of the relationship should be supported by literature and that initial meetings should be properly structured with adequate oversight. While it was acknowledged that these meetings are likely occur at times of emergency or mental illness, nevertheless respondents felt that this only strengthened the case for properly structured meetings and supporting documentation, for their own use, to lessen anxiety and support carers and families.

It was felt that initial meetings and subsequent documentation needed to set down clearly the following aspects of the relationship in order to eliminate possible ambiguities - and set clear boundaries from the outset:

- What is the social worker for?
- How are they going to work with the service user?
- What can the service user expect them to achieve?
- What aspects of the service user's needs should be met elsewhere?

> "I thought it was important that clients should be told right at the start about the structure of their relationship. I was really ill at the time and found myself in a room with this person I had never met in my life filling in some forms. I felt as if he suddenly decided he was going to be my social worker. It wasn't documented for me. I don't know - maybe he was actually assigned. But that is how I experienced it. It could have been that he decided to take over that case. Because as it turned out, he was quite a predatory person and I think he saw an opportunity from the start. Some of these departments are sloppily run. It should be arranged. There should be a meeting. But it could be lack of time and resources. It might be with the best of intentions. There may not be time in an emergency for an introductory meeting."

> "I think I was quite surprised that there isn't more regulation - that there aren't leaflets explaining the relationship. I had assumed it was just me. I thought other people would have had more introduction, a gentle build up. I just thought it was my first contact."

> "I didn't know where they are based. It's so nebulous. It's crazy. And they can be difficult to get hold of because they are in court, or on home visits. It would be nice to have some set times to contact people."

33.

Phase 2: Issues that respondents wished to emphasise

1. Adding structure (continued)

> *"I think it's really important when you first meet your social worker that you should be given clear guidelines on why they are there. Who their manager is, and what department they work for."*

> *"It's not defined. No one gives you a bit of paper saying what a social worker does. That would be a start. At least you would understand what someone's job is. I think that is something that a professional body should produce that is then clearly seen to be independent of the service provider."*

> *"There was no formal meeting where another party, potentially my psychiatrist, could have said 'This is your assigned social worker and this is going to be his role. These are the parameters within which he will work, and this is how his work will relate to our work together'."*

Phase 2: Issues that respondents wished to emphasise

2. Addressing the power imbalance

The most commonly occurring phrase throughout both phases of the research was the "power of the social worker". Many respondents described circumstances where they had felt trapped in a relationship that had never been properly defined to them, and lacking control or a feeling of equal participation in the decision making process had led to strong feelings of fear, sometimes dread of visits. Descriptions of the relationship were characterised by such questions that had no obvious answers such as:

- How does this relationship end?
- Can I ever extract myself?
- Will the social worker or their team stay in my life forever?
- If something goes wrong, who do I go to?

> *"A lot of people are quite scared of social workers. Because of the power they have. The power can be for good or ill. And I have had a very positive and a very negative experience - even within the same social worker."*

> *"These social workers are extremely powerful people if they are approved. They can take away people's liberty if they are approved *. They have a huge amount of power."*

*'Approved Social Worker' or ASW, is a registered social worker who has completed statutory training which gives the power to assess for section.

Suggestions

A number of suggestions were given by respondents as to how this could be addressed and so relieve the feelings of anxiety:

- To better structure the relationship (see above).
- To document the chain of oversight at inception.
- To improve the training of the social worker.
- To increase the frequency of re-registration.
- To involve service user feedback within registration and other settings.
- To allow services users to decide and change the setting for meetings.
- To involve independent bodies in the drawing up of a charter for service users.
- To provide channels for issues and complaints that do not result in loss of services.

> *"The minute I complained about my psychiatrist, services were taken away from me. It was like being punished. If clients of social workers complained, I would hate to think the same thing might happen."*

Phase 2: Issues that respondents wished to emphasise

3. Clarifying the role of the social worker

Most respondents voiced serious concerns about the ways in which boundaries between social and medical intervention were blurred by the role of the social worker in their life and that this was a systemic rather than practical problem. For one respondent, this had negatively affected her relationship with her GP.

> *"She gets all my medical details and I think that's wrong. I have given up telling my GP anything personal because it gets to her and she spreads it around the so-called team that she works for."*

It was felt that the role of the social worker within the mental health team, and versus the Mental Health Act required clarification.

> *"*[Social workers] *...becoming quasi-doctors - that is totally wrong and needs to be stopped. When they become approved mental health practitioners that have the right to section people. [If they have been involved in medication discussions] .... there is supposed to be a gap between the social side and medical side so the social worker is supposed be independent when looking at a decision on sectioning. How can they be? That is something the regulator worker needs to address very urgently."*

Respondents felt that there were two ways in which this could be partly addressed. One wondered whether limits should be set on caseloads and that there should be a maximum number of service users assigned to each care coordinator:

> *"Quite often when there are child protection issues it emerges that the caseload was too high."*

Additionally it was felt that, because circumstances and the quality of a relationship with a social worker will vary considerably, there should be an opportunity for consent to share medical information to be given formally. This would allow the service user to retain control.

> *"If the social worker is the person that sees the client most in their own home and the client had to take a lot of anti-psychotic medication and had issues with that, there should be something where the social worker can ask the client if it's ok to discuss that with someone. The client should also have power to give permission for these things to be discussed. To give their consent in a structured way."*

Phase 2: Other ideas created by respondents

All respondents discussing the study with us found that the findings prompted ideas for improvement to services that had relevance for both practitioners and service users.

When considering the issue of initial meetings, while acknowledging that certain emergencies might preclude the possibility, one respondent felt that literature and documentation should be available in advance. This, it was felt, would help organise thoughts in advance of the first interview so that more accurate and salient information can be given, and ensure service users meet their social worker / the team knowing better what to expect and consequently with lessened feelings of anxiety. Another survivor felt that initial interviews would be much improved by some outline discussion of boundaries.

Discussing the issue of boundaries, as in the first phase of research, drew out the complex and far reaching nature of the issue for both service users and social workers. It was felt that some kind of discussion forum that brought together agencies, practitioners and service users in a safe environment would be a huge step forward and could provide benefits to all parties as well as promoting and explaining the importance of the issue.

> *"Wouldn't it be good if there was somewhere you could go to where there was a representative from each of these agencies. Some kind of organisation where you could take an issue and have a calm reflection back, from people from these three different entities* [social worker / service user / service manager].*"*

> *"This would be a place for both service users and maybe a social worker, who had naively got themselves into a situation where maybe they have feelings for a client or something similar? A safe place to share."*

It was suggested to respondents that the above forum might be an online setting as are many online support groups in other fields such as drug and alcohol recovery - which elicited strong agreement.

Suggestions

Other ideas that were spontaneously suggested during discussion included:

- Refresher boundaries training as well as initial boundaries training.
- Anonymous feedback from service users within refresher boundaries training.
- GPs given the power to end the service user / social worker relationship.
- The involvement of independent voices within the complaints procedure.
- Panels of people using services that have power within reviews of services.
- Review meeting with social worker including independent voices.

> *"I had my therapist to talk to but someone else might not have that. In my case, nothing came of reporting to the manager."*

Phase 2: Other ideas created by respondents (continued)

One respondent wanted to see a "mystery shopper" approach - whereby anonymous feedback was collected from volunteer users of services and fed back to teams, which would highlight problems early on, identify practitioners who need more training or supervision, show where communication channels were poor and allow people using services to feed back into the system safely.

> *"There should be more opportunities for people to report their experiences, like this exercise."*

Underscoring all of these ideas was the requirement to adequately fund new initiatives.

> *"There should be more money for training social workers. The government has the intention of improving the client's experience. Top-down directives are aimed at stopping things going wrong, but may be creating more problems."*

Phase 2: Implications for training

Overall, it was felt that addressing the issue of boundary violation within social worker training was a complicated issue but because of its seriousness it should be intrinsic to training. It was felt to be complicated because boundary violation can occur:

- By a predatory person.
- With great harm or little harm.
- Unconsciously.
- Naively and thoughtlessly.
- Sometimes with permission from the user of services.
  (for example *"it is sometimes OK to personally disclose to me"*).

Consequently it was felt that social worker training should include:

2.   Safety making language and actions underscoring all aspects of training.

> *"If a young and inexperienced social worker visits the home of a client, a client who may be disturbed, the social worker is open to the client misinterpreting their presence in the home. There are all kinds of very innocent things that can trigger off feelings of threat and persecution. A social worker can, without realising it, represent a threatening or persecuting figure from the client's past. Having a clear idea of safe vocabulary and body language, if the social worker adheres to the right ways of speaking and relating, it will protect both people. These things should be in training right from the word go, in basic training. Because then it becomes simple. It would be something that all social workers would be relaxed about by the time they graduate. It would be second nature."*

> *"Some people are sensitised to boundaries and very anxious and if you are listening to anything that your social worker says and they are not using safe language, that just leads to anxiety. People like me, worrying about what the language meant. Even if it didn't mean anything."*

3.   A set of basic principles, tested against a variety of scenarios, cross checked by referring to other sources of information about the person using services.

> *"Teaching people how to assess situations on their merits. Real life situations are complex. It's important to have some other body or person in the equation to avoid the individual social worker having too much power."*

4.   Role playing both service user AND practitioner roles.

> *"Role playing would be brilliant. Pretending to be the client would be powerful. Putting themselves in the shoes of somebody who was afraid of the visit from a social worker. Role playing someone who was vulnerable. So that when they are training they have to think about how they would feel if someone came into their lives with the power to take their children away."*

Appendices

- Notes for researchers on research ethics

- Discussion Guide

- Research Stimulus - Hypothetical Scenarios

- Research Stimulus - Pre-phase 2 pro forma

- Research Stimulus - Key slides from the presentation Professional Boundaries commissioned by the General Social Care Council (GSCC)

Appendix 1: Notes for researchers on research ethics

The scope of the research did not allow us to refer explicitly to individual cases of boundary violation and explore these in detail - particularly since the findings would be shared among other members of the group - even though made anonymous. There is a limit to how much can be explored that is highly sensitive in this particular research setting. It is to be hoped that discussion of this report and respondents' experience of the research process will throw light on how we might construct phases that go deeper into episodes of crisis and violation. During this research, great care was taken to ensure and promote respondents' feelings of safety and security both during and after the interview stages. Key to this was:

- a detailed briefing for each respondent given by Lynn and Patrick Parker on the structure and use of the research and the anonymous nature of the feedback that would be reported;

- the presence of Lynn Hiltz from WITNESS who provided support to respondents throughout each interview and who, at the conclusion of the interview, checked with each where they were going next, and that they were feeling comfortable and relaxed about how the interview had gone. Lynn kept open the lines of communication to each respondent, post the interviews for Phase 1 and Phase 2;

- conducting discussions in an informal tone of voice and using non-directive questioning techniques and allowing respondents to answer in an open-ended way;

- explaining to respondents that they could come back to the research team at a later stage to add to, or qualify their answers or provide additional thoughts that had *"occurred to them later"*, by contacting Lynn Hiltz by email, telephone or letter.

Time was taken to ensure each respondent answered in their own style, in their own time, and, by using non-directive interview techniques, in their own words. All respondents were briefed that they could pause or terminate the interview at any time, or could omit to answer in any topic area they found difficult or upsetting to discuss. In fact this did not prove necessary to any respondent during our research.

Investigating sensitive and confidential issues can give rise to difficult feelings after the interview has finished - there can be a delay before these are fully felt - they may not be felt at the time of the interview. For some respondents taking part in this study this had occurred but it had been offset by the positive experience of taking part.

> *"It's empowering to know you are doing something and someone is hearing your voice. But it has also stirred up a few things."*

Research teams might consider catering to possible "research comedown" by making follow-up calls to respondents to check their well being and anxiety levels, and to provide take-away literature alerting them to the possibility of "comedown" and suggesting how to factor in precautions such as scheduling time with a friend, carer or family member.

Appendix 2: Discussion Guide

- Introductions and project purpose, session structure, recording.

- Completely confidential, destruction of recordings

- Nothing you say will get anyone into trouble

- No right or wrong answers, don't evaluate, just say what you think

- How to respond after the session

Warm up

- If I say "social worker" what does that conjure up to you?

- What do you think it conjures up to most people?

- What is a social worker there to do?

- Does it make a difference if they are male or female? How does that work?

- Do all social workers basically have the same approach or do they vary?

Imagine you were describing the experience of having a social worker to a friend of yours.

- What are the good things about having a social worker? (capture)

- What are the not-so-good things? (capture)

A part of this project is to understand more about the relationship between social workers and users of services.

- Are there things that should change generally in the relationship between service user and social worker?

- Are there things not provided by social workers that should be?

- If you could change the job spec, what would you add or take away?

Problems

- Supposing you have an issue to do with your social worker – who would you talk to?

- What kind of issues can you think of that could be a problem?

- What would constitute inappropriate behaviour by your social worker?

- Is this something you've thought about before?

- Do you have anecdotal or hearsay experiences you'd like to talk about?

Appendix 2: Discussion Guide (continued)

Direct / indirect experience

- Have you had any personal negative experiences?

- What advice would you give to a friend who had a bad experience like this?

- Have you thought about this before?

Mapping – open ended

In this project we are trying to better understand the relationship between social workers and users of services. We are trying to understand how service users feel about social workers' behaviour, attitudes, and manner towards them.

In short – we are trying to get service users' views on what is OK behaviour and what is not OK, what sort of things is it ok for them to tell you or ask you, which things are off-limits questions or behaviour? Do you understand what I'm driving at?

We might describe this as a professional boundary between social workers and users of services. Or we might say that in doing or saying a particular thing the social worker has "crossed the line".

We recognise that this will vary from one person to another – there might be times when it's OK to cross that boundary and times when it isn't. Let's draw a physical line on the table that represents this professional boundary.

- Thinking about yourself, what are your personal boundaries in terms of what a social worker can talk to you about?

- How about their actual behaviour?

- Is there a general rule of thumb that can tell us when "the line has been crossed" or does that vary by person or by occasion?

- Does this vary depending on the gender of the social worker or the service user – what role does gender play?

Appendix 2: Discussion Guide (continued)

Mapping – closed

We are talking to lots of different people about their experiences and no two are alike. Everyone's feedback is important. So from some of the people we have already talked to, here are some examples of experiences they have described. I'm interested in how you feel about them. For some of these they might be OK for you personally, but you might think they are not OK generally. So let's talk about that.

- Random order "mini behaviours" per respondent.

- Investigate for each – why do you want to put that in that position?

- Are there circumstances in which this might change position?

- What are they?

- When complete – are there any positions you want to change?

- Is there anything missing from this selection?

- If so, what? Why is that important?

- Earlier in the interview you said "X" – where should that go on this line?

- Can we summarise the differences between the things that are OK and not OK?

- Does this get us any closer to a rule of thumb?

Close

After this phase of interviews we will be writing a report and discussing our findings generally with colleagues.

- What are the most important things I should be telling my colleagues?

- Is there a single "headline" from this that stands out?

- Is there anything else you'd like to tell us?

You can come back to us with more feedback via SAE, email etc.

Appendix 3: Research Stimulus - Hypothetical Scenarios

Your social worker shakes your hand when he/she meets you.

Your social worker says, 'Damn, I forgot to bring a form I needed to fill out with you.'

Your social worker tells you that he/she needs to cut your visit a bit short today because he/she has to go pick up his/her child from speech therapy.

Your social worker tells you that he/she has struggled with alcohol dependency in the past.

Your social worker tells you that you look lovely today.

You are very upset during a meeting with your social worker and he/she hugs you.

You are very upset during a meeting and your social worker puts his/her hand on your arm.

You are out of money for the month and your social worker offers to give you a lift to the benefits office.

Your social worker notices your collection of Harry Potter books and asks to borrow one of them.

You bump into your social worker at Sainsbury's and he/she introduces you to his/her partner.

You notice on a visit that your social worker seems miles away, and you ask if anything is wrong. Your social worker tells you that he/she is thinking about another service user who was verbally abusive with him/her earlier today.

Your social worker tells you that you are an amazing person.

Your social worker tells you that you are such a kind person and he/she wishes that his/her wife/husband listened as well as you do.

Your social worker tells you that if he/she had met you under other circumstances, he/she would have definitely asked you out.

Appendix 3: Research Stimulus - Hypothetical Scenarios (continued)

Your social worker tells you that he/she has had to spend a lot of money travelling to see his/her mother who is dying of cancer and is short on rent money this month and asks you whether he/she can borrow two-hundred pounds from you. He/she promises that he/she will be able to pay you back at the end of the month.

Your social worker tells you that he/she thinks about you all the time.

Your social worker tells you that he/she really enjoys working with you, that you are so much easier to help than his/her other service users.

Your social worker tells you that he/she will always be there for you.

You tell your social worker that you are feeling suicidal. Your social worker gives you his/her mobile number and tells you to only use it in an emergency.

Your social worker tells you that he/she could lose his job for this, but that he/she is in love with you. He/she tells you that he/she can't help who he/she falls in love with.

Your social worker seems like he/she is in a very bad mood. You ask what's wrong. He/she tells you that his boss is just constantly on his/her case and he/she doesn't know how much more of it he/she can take.

You are coming to the end of your work with your social worker and he/she gives you his/her email address and tells you that he/she would love to take you for a drink once your work together is done.

Appendix 4: Research Stimulus - Pro forma for reading interim report

Prior to the Phase 2 interviews, the interim report was circulated among all respondents along with the following pro-forma document.

Please write down and bring to your interview:

- Four things in this report that I most agree with

- Four things in this report that I don't agree with

- Any ideas I have had while reading this report

- Any actions I would like to see coming out of this research

- Feelings I have had about being included in this research

47.

Appendix 5: Research Stimulus - Key slides from the presentation Professional Boundaries commissioned by the General Social Care Council (GSCC)

Appendix 5 : Research Stimulus - Key slides from the presentation
Professional Boundaries commissioned by the General Social Care Council
(GSCC)

Appendix 5 : Research Stimulus - Key slides from the presentation
Professional Boundaries commissioned by the General Social Care Council
(GSCC)

Appendix 5 : Research Stimulus - Key slides from the presentation Professional Boundaries commissioned by the General Social Care Council (GSCC)

Appendix 5 : Research Stimulus - Key slides from the presentation Professional Boundaries commissioned by the General Social Care Council (GSCC)