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**Reported client-practitioner conversations as assessment in mental health practitioners' talk**

**Abstract**

The aim of the study is to show how reported client-practitioner conversations function as assessments. The setting of the study is a rehabilitation course targeted at young adults. The data consist of informal backstage meetings among the practitioners, which do not have an officially stated or recognized task of assessment making. However, the study demonstrates that the meeting talk is rich in reported client-practitioner conversations with a dimension of assessment. The located assessment functions of reported conversations and the accompanied meeting talk are: 1) making negative and positive portraits of clients, 2) treating clients' voices as self-evaluative and influential, 3) presenting practitioners' own past talk as problematic and creating self-advice for future conversations. By making reported conversations visible as everyday assessment practices, the article challenges the one-sided view of assessment as a separate and

formal professional practice, which is conducted with standardized tools such as psychological and social ability tests.

## **Keywords**

reported speech, reported conversations, assessment, backstage talk, mental health

## **1. Introduction**

The setting of this article is a rehabilitation course targeted at young adults suffering from serious mental illness and more specifically practitioners' backstage meetings conducted in the course. During the course there are plenty of face-to-face conversations between the practitioners and the clients. However, the practitioners running the course also have regular informal meetings among themselves without the clients. This kind of practitioners' backstage talk (Goffman 1959), which creates shared understanding of work and of clients, is common to human service work. The backstage talk of the rehabilitation course is rich in describing the condition, behavior and the ups and downs of the clients. When doing this describing, the practitioners often report their past conversations with the clients. In this article we concentrate on these reported conversations from a certain angle: how they are in service of assessment making and what functions they have in this action.

Assessment making has become an important task and a demand for professional mental health rehabilitation and for human service work in general (Sawyer 2005: 283-284). It is seen as central to identifying clients' abilities, needs, and risks, and to making service decisions (Taylor 2011). Standardized assessment procedures are often understood as a way toward more uniform and predictable professional practices. Likewise, the practitioners running the

rehabilitation course are expected to assess clients by using standardized tools. They perform assessments on the cognitive and social skills of clients by using a set of psychological and social ability tests. These tools are supposed to be strictly followed and their function is to produce measured and quantified knowledge about the strengths and weaknesses of the clients and thus predict their future risks and service needs. However, it is not only these standardized tools of assessment, but also more informal assessment making practices that are carried out during the course.

Noordegraaf (2008: 9-11) writes about two main approaches to the study of assessment. The “evidence-based” approach relies on diagnostic parameters that might predict clients’ future needs and risks, while the “process approach” relying on ethnomethodological research orientation focuses on assessment making processes in everyday interactions (Noordegraaf et al. 2010; Holland 2004: 1-4). By studying reported conversations as assessments which take place in everyday talk we stress the importance of qualitative assessment practices besides just standardized clinical assessment tools (Gilgun 2004). Reported conversations, as one form of such practices, are worth studying and making visible in detail because as a common and mundane way of communicating their role in assessment making remains usually unnoticed (Garfinkel 1967).

In recent years, a number of studies have concentrated on everyday client-practitioner interaction in mental health including topics related to assessment. These studies have demonstrated how practitioners make conclusions, summaries, diagnoses, and reformulations based on clients’ turns of talk and how clients respond to these interpretations in the sequences of interaction (e.g. Antaki et al. 2005; Antaki 2007; Voutilainen et al. 2011). In the data of this study the clients’ prior talk is also reinterpreted by the practitioners but without the presence of the clients. Hence, the ones who are able to respond to the reported client-practitioners

conversations are the other practitioners as co-workers and team members. There seems to be little research dealing with reported client-practitioner conversations as everyday assessment making in encounters among practitioners.

## **2. Reported speech and reported conversations**

Our article draws from the literature on reported speech. Much of this research can be traced back to the work of Bakhtin and Volosinov (Slembrouck and Baynham 1999: 453). According to Bakhtin (1981: 337), “the transmission and assessment of the speech of others, the discourse of another, is one of the most widespread and fundamental topics of human speech”. The ways in which reported speech is present in face-to-face interaction has been examined in ethnomethodology, conversation analysis, narrative approaches, and discursive psychology. In this text we make use of ethnomethodologically-oriented studies done on reported speech (e.g. Buttny 2004; Holt and Clift 2007; Tannen 2007).

We define reported speech as a prior talk that is “used and put into context in a present conversation” (Buttny 1998: 48). Reported speech can be direct or indirect, although they are often difficult to differentiate (Coulmas 1986; Holt 2000: 427-432). In direct reported speech the speaker simply seems to quote the actual words of the original speaker, like “he said I am really depressed”. In indirect reported speech the “original” speech is harder to separate from the reporting talk, since it does not include the actual words and sentences spoken by the original speaker but instead conveys only its content. It can take the form of a summary of previous utterances and sometimes may even seem to convey the feelings and thoughts of the prior speakers (Holt 1996: 220-221 and 2000: 429; Buttny 1998: 48; Buttny 2004: 97), like “he told me that he has felt really depressed” or “when discussing with her she saw that her situation

has become better”. The reporting speaker might also report his/her own prior talk directly or indirectly, like “I replied to her that this is not my fault” or “I became angry and asked her to leave the room immediately”.

Reported speech has been characterized as an economical and effective way of producing evidence (Holt 1996: 225-226; Stokoe and Edwards 2007: 335; Wooffitt 1992). It makes the talk sound accurate and reliable by distancing the speaker from the message and by creating the speaker as a witness of the “original” talk. However, verbatim recall is often not possible even when the speaker just seems to quote prior direct words of another. Recalling and re-using former speech in present talk inevitably transforms the original talk. The reporting context is thus a crucial element in analyzing reported speech. It is not possible to divorce the context of reported speech and reporting from another (Volosinov 1971: 153; Holt 1996: 222). Reported speech is always recontextualized: past talk is altered when reporting speakers use it for the purposes of the present context (Buttny 1998: 48-49). So, although quoting original speakers creates the impression of authenticity, reported speech is not a disinterested report of events.

The informal backstage meeting talk among the mental health practitioners under examination in this article creates a special reporting context. In earlier studies reported speech has been studied both in ordinary conversations and in institutional contexts. Researching meetings among mental health practitioners belongs to the latter, focusing on “talk at work” (Drew and Heritage 1992). Drew and Heritage (1992: 25) name an orientation to institutional tasks as one of the important dimensions in institutional interaction, which has to be taken into account when analyzing talk at work as is done in this article (about the institutional tasks of the rehabilitation course, see Section 3).

Our focus is on such reported speech, wherein the practitioners (reporting speakers) report past conversations between themselves and their clients (original speakers). To put it more precisely, we concentrate on the practitioners' reports on the sequences of turns by themselves and the clients (Holt 1996: 232-233). This reporting is often done in a story telling format, which we define, by applying Holt's (1996: 232) ideas, as a report of "how a conversation developed and the stances of the speakers as displayed in their talk" (see also Tannen 2007: 105-107). Holt (2000: 451) writes:

When people tell stories, they want the recipient to agree with their interpretation or assessment of the incident (e.g. that it was funny and complaint worthy). However, rather than making their assessment of the event explicit, reported speech (within a sequence containing implicit assessment) can be used to give the recipient the access to the utterance in question, thus allowing him or her to react to it and the teller to then collaborate in that reaction.

The above citation describes aptly the processes of providing and receiving reported conversations in the talk among the practitioners in the meetings. Told stories about past conversations with the clients serve as a resource in making joint assessments. Often reported conversations already include the elements of assessment and thus also preferred interpretations, but it is the recipients' responses and reactions that make implicit assessments "into being" and shared.

### **3. Research setting, data and analysis**

The setting of this study, the rehabilitation course, represents a new way of organizing mental health work that is planned for 18 to 30 year olds, who have most often been diagnosed with schizophrenia. It is organized by a non-governmental mental health agency. The course lasts for three months with 5 to 8 clients on each course. The courses are located in a terraced house, where the clients live during the whole course. The staff group consists of five health and social care practitioners. The clients come to the course from various institutional places such as psychiatric hospitals, nursing homes, and supported housing units. Some have lived with their parents or in their own apartments, but have had problems with these living arrangements.

The institutional tasks of the rehabilitation course are to promote individual change, to develop plans for further treatment, and to reduce the need for institutional care in psychiatric hospitals or nursing homes. Fulfilling these tasks requires assessing the clients to see how the clients progress along their individual rehabilitation paths. The course is not a treatment institution: its tasks do not include making mental health diagnoses, or conducting psychotherapeutic or medical work.

The course program is tailored to each client. It contains conducting psychological and social ability tests, learning about illness management, developing social skills, and training in managing daily life, like cooking, cleaning, and planning daily and weekly schedules. All these activities include continuous encounters and conversations between the clients and the practitioners. Our assumption is that assessment making often plays a part in the course's mundane encounters, although it is usually recognized to be present only on special assessment making occasions like in doing the standardized, quantified tests.

Our data include six informal audio-recorded meetings among the practitioners, which were conducted during the same rehabilitation course in 2010. The longest of them lasts 81 minutes and the shortest 17 minutes. The researchers were not present in the meetings. Our

larger data corpus includes audio-recorded meetings from other courses as well, but concentrating on one course's meeting talk is a coherent choice since the talk deals with the same clients. The chosen data is also rich enough to analyze reported conversations as assessments.

In defining these meetings as informal and as backstage talk we refer to their off-the-record status; no minutes are written on them and they do not try to make formal decisions on how to proceed with individual clients. All the participants do similar work with the clients and in that sense they have equal status in the meetings. The practitioners characterize the meetings as places where they “just” inform each other about the last week's events and incidents and about the situation and condition of each client. They are thus first of all seen as places for information sharing. The meeting talk however contains also assessment making, and it is important to make this often unnoticed everyday assessment visible. This text illustrates one way of doing this everyday assessment in the meetings.

Although the clients are physically absent from the meetings, their speech is echoed in them. The data contain thus plenty of the clients' direct and indirect reported speech. A noticeable feature of the meetings is that the practitioners frequently present reported speech in the form of a conversation between two parties: the reporting speaker him/herself and the client. Reported conversations are short stories connected to various mundane encounters and events within the course. Our preliminary observation of the meeting talk was that the reported conversations often seem to have a dimension of assessment.

The first step in the analysis was to identify all the reported conversations in the data. The selection criteria in this identification were that they contain direct and/or indirect reported speech (see the definitions in Section 2), and include at least two prior speakers (the reporting speaker him/herself and one of the clients) whose quoted talk form interactional stories including

sequences of turns (see the definition of reported conversations in Section 2). We identified altogether 75 such reported conversations in the data.

The second stage of the analysis was to examine which of these reported conversations seem to accomplish assessment making (for instance, produce evidence of progress and regress of the clients, or of the successes and failures of rehabilitation tasks). We discovered that the majority of them, 69, contain assessment making. These 69 reported conversations and the responses to them form the core data of this study.

In the third stage of the analysis we explored more closely the functions of assessment accomplished in and through reported conversations. We ended up with three functions: 1) making negative and positive portraits of clients, 2) treating clients' talk as self-evaluative and influential, 3) presenting practitioners' own past talk or behavior as problematic and creating self-advice for future conversations. The functions differ from each other depending on who (the clients or the practitioners) is assessed and how. The functions often overlap in the reported conversations and accompanied meeting discussions. The first function is the most common. The other two functions almost always somehow make use of client portrait making.

In the following section we analyze the display of each of these functions by concentrating on how the reported conversations are brought into the meeting talk and on how they are responded to by the practitioners. We also demonstrate how client portrait making is embedded to the two other functions. In the beginning of each function section (Sections 4.1, 4.2 and 4.3) we explicate the main features of the functions, which we located in the data and which thus served as the criteria in forming the functions. The excerpts chosen for the detailed analysis represent these main features.

The data were transcribed verbatim. The original language is Finnish. Translating is never a straightforward process, but we have aimed to be as loyal to the original expressions as

possible. The actual names of the clients in the excerpts have been changed to fictitious ones and all references to localities and services that might risk the anonymity of the persons involved have been removed. The Board of Directors of the courses' host NGO gave the permission to collect data. We gave written and oral information about the research to the clients participating in the course.

#### **4. Assessment making functions of reported conversations**

##### *4.1. Making negative and positive portraits of clients*

The most common assessment function of the reported conversations is to make positive and negative portraits of the clients. We located altogether 53 reported conversations displaying this function. When accomplishing this function the practitioners report their prior conversations with the clients and the clients' "own" talk embedded in them as evidence of the clients' state of mind, condition, and behavior. This reporting and accompanied meeting interaction produces portraits for the clients in regard to their rehabilitation processes. Positive portraits (20) are linked to progress and negative portraits (33) to regress or stagnation in rehabilitation processes.

Previous research shows that reported speech often serves the purpose of creating evaluative portraits of the quoted people (Buttny 1997; Hall et al. 1999; Buttny and Williams 2000). Making negative evaluations of people is common for complaints accomplished through reported speech (Drew 1999; Stokoe and Edwards 2007). Complaining can also be said to be present in our data when negative assessments are made of the clients in regard to rehabilitation expectations. However, expressing appreciation in cases assessed as being opposite is also common. Positive and negative assessments, appreciating stances, and making complaints

through reported conversations are not divided according to the clients, but can be present in assessing one and the same client in meeting talk. Our first excerpt serves as an example from this kind of talk.

Before the following excerpt, the practitioners have discussed what would be the best possible place for the client after the course. They agree that totally independent living is not yet possible at this stage, since the client needs professional support in the future as well. The assessment continues (in the excerpts “xxx xx” signals direct reported speech and <xxx xx > indirect reported speech):

Excerpt 1

P4: but really really also yesterday when their place was cleaned when we were cleaning their place so it was truly it was so exceedingly low the level where it started that (P1: erm) we did everything again totally together (P1: yeah) from start to finish and she succeeded in doing nothing with her own initiative (P1: yeah) although I tried to give as simple instructions as possible (P1: oh oh) like “put some water into the bucket” (P1: yeah) so water went into it but only two centimeters (P2: yeah) and then that dry mop sticks there in the bucket and < she sees that everything is ready and cleaning can be started > (P1: oh god) (P2: yeah) water must be still added and detergent (P1: yeah) is missing and the mop is dry that is what she is not able to see (P1: yeah)

P2: then at some point when she had a kitchen turn she like gets stuck there if you’re not immediately giving her instructions (P1: yeah) or something if (P1: she runs away) she runs away ((laughing background)) then if you don’t like go there immediately she leaves

P1: pink coat just zips away she is there a short time stands there sticking out and then if somebody doesn't come in like a minute to instruct she leaves

P4: but she was lovely in this play she took responsibility in it (P1: yes she was) <she wanted to be a narrator and she wanted to be in that group thing > and then I even asked her yesterday "do you feel tense in being (P1: yes) there" "well not really"

P2: she was just a perfect narrator

P4 starts telling the story about the event that happened the day before. She creates a scene (the room of the client), the activity in question (cleaning) and the participants (herself and the client). Vivid description of the cleaning activity with a mop, a bucket, and the ways how participants oriented to them and used them produces a sense of authenticity. The stance of the speaker is clear from the very beginning. She makes an assessment by estimating the level of the client's cleaning skills as being "so exceedingly low". The "fact" that she and the client performed all the cleaning "totally together" serves as evidence. The following reported conversation provides further evidence for the assessment of the client's everyday skills. The direct quote from her own speech "put some water into the bucket", the client's concrete response to this instruction (putting only two centimeters of water into the bucket), and the client's own evaluation of her response in the form of indirect reported speech (<she sees that everything is ready and cleaning can be started >) support the assessment already made in the beginning of the excerpt. The practitioner still strengthens the assessment by listing all what went wrong in the cleaning and by simultaneously producing the criteria of proper cleaning. As the recipients of P4's story-formed reported conversation, P1 and P2 collaborate in producing this assessment. Their minimal responses during P4's extended turn function as continuers

displaying understanding that the story is still in progress. They also assess (“oh oh” and “oh god”) what was said as remarkable (Goodwin 1986: 207).

In the reported conversation produced by P4 the client is created as a person lacking self-initiative. This is a negative portrait from the point of view of expected progress in rehabilitation. During the storytelling both P1 and P2 use several “yeah” acknowledgement tokens that might signal efforts to move into speakership (Jefferson 1984). After the first story P2 also takes the speakership and produces a second story about the client’s behavior in the kitchen that displays her analysis of the first story and agreement with its “complaining” content (Arminen 2004). P1 collaborates by supplementing and continuing this second story. The client’s negative portrait becomes thus stronger and more evident when the same lack of self-initiative is to be verified in her “kitchen behavior”. Without clear instructions she “gets stuck” or might even run away from the situation, or as P1 puts it: “pink coat just zips away”.

Right after the turns of cumulative negative assessments the same practitioner who first started “complaining” takes a totally different, appreciative stance by telling the third story by using reported conversation. She starts describing how the client had taken part in the play and its rehearsal. The client is now assessed in a new situation and in a new light as a person who takes responsibility and has initiative. The evidence of her self-initiative is produced by using her indirect reported speech: she herself wanted to participate and even wanted to take the role of a narrator. The reported turns of talk between the practitioner herself and the client verify that the client has also self-reliance: when the practitioner had asked about her possible tenseness, she had said that she did “not really” feel tense. P1 and P2 align with the story and positive assessment with their “witness” statements: “yes she was”, “she was just a perfect narrator”.

#### *4.2. Treating clients’ talk as self-evaluative and influential*

The reported conversations and the accompanied meeting talk can treat the clients' prior talk as self-evaluative and influential in assessment making. We identified 16 such instances in the data. In them the practitioners invoke the clients' talk as the words of an authority (Buttny 2004: 98). The clients are defined as capable of analyzing and evaluating their own condition and situation; their own self-evaluative words are taken seriously. This feature distinguishes these reported conversations from the assessments where the clients' prior talk is used merely as material in "top down" professional assessment making (see Section 4.1). Taking the clients' own evaluations seriously does not mean, however, dismissal of the practitioners' expertise. As the reporting speakers, they decide how the reported conversations and the clients' "own" words in them are presented and used.

The next piece of meeting talk continues the practitioners' discussion about the client moving back to his own apartment after the course. The apartment is located in the neighborhood called Palola.

Excerpt 2

P3: Palola is not like ((clearing one's throat meaningfully)) by any means the best place for detoxification or to have an apartment in general (P1: erm) where no one visits

P2: what about, could it be possible by the way to get psychiatric home rehabilitation there

P1: I don't know but < he doesn't want to let anyone in to that apartment > (P2: of yeah) it was discussed (P2: erm) when the mother asked "have you been to that apartment (P2: erm) and seen that after all there are all the necessary things and that those things would just have to find their places" so I then said to her that "I've discussed this with Matti"

(P2: erm) that “I’ve offered (P2: erm) to go there with him and help him (P2: erm) with putting things in place” but <he said that he’ll get them himself> which I understood to mean that <he doesn’t want me there > and then it was agreed that if Matti doesn’t want you there then you can’t go

In the first turn P3 expresses her concern about the forthcoming move. The concern is linked to the client’s current phase in his rehabilitation process. He tries to get rid of substance abuse. P3 displays doubt about whether moving to this particular neighborhood in this phase of the course is a good idea. She seems to connect negative meanings to Palola as not being a good place for the client in the detoxification process to live in. Furthermore, she displays doubts about whether living in one’s own apartment in general works in this situation. She reasons this doubt by indicating that living in the apartment means being there totally alone (“where no one visits”). The wrong kind of neighborhood and loneliness are thus assessed as serious risks in rehabilitation. P2 displays sharing of these concerns in her response by proposing one possible solution for reducing the anticipated risks: psychiatric home rehabilitation.

P1 comments on the proposed solution. She starts by saying that she does not know whether psychiatric home rehabilitation would be available in this case. This is not even a relevant issue to find out about here, because <he doesn’t want to let anyone in to that apartment>. P1 presents herself as knowledgeable about the client’s wishes. This knowing is made evident and factual by reported speech and conversations, which she herself has heard and been part of in real situations. She reports two different conversations. The first had been between herself and the mother of the client. The second conversation, which is embedded in the first one, had also two participants: P1 herself and the client. The mother had asked P1: “have you been to that apartment and seen that after all there are all the necessary things and that those

things would just have to find their places”. The question includes an indirect suggestion that the apartment should be arranged by somebody. By presenting direct quotes from her own speech as a response to this suggestion P1 constructs herself as a person who knows the client’s opinion on the matter. The reported conversation between herself and the client constructs this knowing as very certain; the client had announced to her that he does not need any help and does not want P1 to visit his apartment. The other practitioners’ minimal responses to the reported conversations function as continuers, but indicate also alignment with the reporting speaker (especially P2’s response “of yeah”) (Goodwin 1986).

The first part of the conversation creates a concern that living alone in Palola will be a serious risk when it comes to the client’s rehabilitation process. However, this assessment does not lead to the conclusion that moving back to Palola and living alone with no visitors should be prevented. Instead, P1 brings the client’s own speech and will forward by reporting his prior talk and her conversation with him. It is the client’s own evaluation about his situation that should be respected and followed in spite of the possible risks.

The next example deals with psychiatric problems. The practitioners have talked about the client’s feelings of fear and aggression, which are connected to hearing voices. The conversation continues with P4’s description of her encounter with the client.

#### Excerpt 3

P4: and there was talk about < whether she feels that they are those daily issues (P1: erm) that do those voices appear daily and so on > (P1: erm) she replied that “they don’t appear daily (P1: erm) but every now and then” (P1: erm) < now some weeks ago there had for instance been such a situation in a store that she had suddenly got an unreal feeling and then she couldn’t do those purchases that she had thought about beforehand > (P1: yeah yeah) I said that “how did you act in that situation that did you go away (P1:

erm) from the store did you interrupt everything what you were doing” (P1: erm) so <she said that she just thought that she can make some purchases and then goes away but (P1: yeah) then she couldn’t however do those that she had thought about beforehand > (P1: yeah) “but those don’t come often” she said (P1: yeah)

The reported conversation between P4 and the client is the core of this story. As a reporting speaker P4 takes the floor and the other participants take the position of the audience by giving minimal responses that encourage P4 to continue story telling. P4 presents her turns in the prior conversation as questions. The first reported question (< whether she feels...>) is an indirect quote, because P4 does not exactly say that she asked the question. However, given the presence of only two parties in the described encounter, it is easy to hear that she was the one who made initiative and posed the question to the client. The other question P4 presents as a direct quote from her own prior talk (“how did you act...”). When P4 also quotes the client’s answers to her questions, the first part of the reported conversation follows a questions-answer structure or an interview format (Silverman 1997). The first of the client’s answers is in the form of direct reported speech. The second, long quote (“so she said”) is indirect reported speech.

What is then the interactional task of this reported question-answer conversation? It makes the client knowledgeable about her own psychic condition. She is the authorized person to report about the frequency of hearing voices and about her feelings in hearing situations. The client’s story of hearing voices when shopping is regarded as being worth of analyzing more. The authorship of this analysis is given primarily to the client by posing the follow-up question to her. Her reported answer about how she acts and copes in these shopping situations strengthens even more the impression that the client’s own expertise is valuable. All in all through the reported conversation the client’s self-evaluation is produced as important

information for the practitioners. The constructed client portrait is positive: she is able to reflect on her own situation.

#### *4.3. Presenting practitioners' own past talk problematic and creating self-advice for future conversations*

In the two previous assessment functions of reported conversations, the focus was on the clients' prior talk and their turns in conversations. In the third function the gaze turns more on the practitioners' own prior talk. When discussing the involved practitioners' parts in the past conversations the practitioners assess them as being problematic in some sense. The practitioners "complain" about their own prior ways of talking and behaving in the reported situations, and thus hold themselves as responsible and accountable (Buttny 2004: 120). This self-criticism is followed by self-advice meaning that the practitioners create forthcoming, "fictional" conversations with the better turns of talk to be displayed (Buttny 2004: 97). We located 25 reported conversations of this kind in the data.

In the next excerpt the discussion continues the assessment of one client. Before that the practitioners have evaluated the client's condition. They then move on to assess another matter:

##### Excerpt 4

P3: And if he still asks something ((refers to the client's habit of asking permission from different workers that have already been discussed and declined by the keyworker)) you know he tries all kinds of things that (P2: erm) that < shall we go there and let's go > and then he even asks you when I say (P2: erm yeah) that < we won't go > (P2: yeah) so guide him then in those matters straight to me (P2: yeah) that talk to Laura (P2: yeah) because well (P2: this is how we'll do it) you can well see that he

P2: tries to play between workers

P3 starts giving instructions to her colleagues. She refers to the past and repetitive behavior by the client as being known by all the workers (“if he still asks...”). P3 quotes the client’s prior way of talking: “shall we go there and let’s go” and presents this reported speech like the client’s usual way of talking to the practitioners. This way of talking is then linked to usual prior conversations with the client, when P3 produces his own typical response to this repeating question: “we won’t go”. The description continues by presenting the client’s usual next turn: despite one practitioner’s no-answer he still tries to gain permission from the other workers. This reported conversation formulates the client as a person “who tries to play between workers” (negative portrait). P2’s responses to P3’s talk act first as continuers and then as a completion of the negative assessment of the client when she finishes the sentence started by P3 (cf. Goodwin 1986: 209).

What P3, with the support of P2, produces as problematic in these prior conversations is not that her colleagues would have given permission for “going” after her denial. Instead, they criticize themselves for letting the client play between them. The self-advice following from this self-evaluation is that in the future they all should be more aware about this possibility of client “playing” between them. The imagined, preferable future conversations concretize this advice. The next time when the client asks permission from somebody else than P3, his question should be responded to by saying “talk to Laura” (to P3).

In our last excerpt the practitioners show concern about the client’s capacity to manage his daily affairs, like remembering his laboratory appointments:

Excerpt 5

P3: well I waited until the breakfast table before I asked him “was it yesterday when I said to you (P1: erm) no it was on Tuesday I said to you that today you don’t have lab because the lab time changed it is now exceptionally on Thursday and I have now reminded you both weeks that this ((refers to the lab appointments)) can’t like be our responsibility although it is ultimately our responsibility but that it should be your initiative that you come to say that by the way I have that lab today (P1: yeah) so this is not the way to go“ he laughed when I asked “would you have remembered the lab ” “I guess I would have” ((imitating the voice of the client)) I said “the point at which you would have remembered is when you would have swallowed your Leponex ((the medicine that should not be taken before the lab tests)) or then at noon when the appointment time would have passed” so nothing ((refers to that he doesn’t reply)) he laughed in a kind of funny way

P1: he would really need some home visit team there

P2: yes he would

P3: he would

P1: Mattila ((municipal care manager)) said "it will begin in Mieli ((NGO in mental health)) in the autumn this kind of a bit similar like that psychiatric home rehabilitation in Kuntoutus ((NGO in mental health)) but they could visit even more often that they could visit even twice a week” I just mentioned then that “we would have one person who would need this but at least at the moment he is not willing to” but it would probably be something which should be discussed with him and at least inform also Hoito ((the client’s treatment institution)) (P3: yeah) that it would perhaps be worthwhile

P3 starts by reporting the past conversation with the client. As a reporting speaker she first quotes her own long turn, which begins with the question (“was it yesterday...”) and turns into a complaint presented to the client. She portrays the client as the person who lacks self-initiative and responsibility in his own matters: he misses the lab appointment if he is not reminded about it. In her self-quotation P3 also negotiates the responsibilities between the workers and the clients. The core message of this reported speech of her own, targeted to the client, seems to be that the client should change his behavior in a more self-responsible direction in the future. The client’s responses to this message are presented as vague. He laughed and said “I guess I would have” when answering to P3’s checking question “would you have remembered” (the lab appointment). P3 continues reporting the conversation with still another quoted question of her own (“the point at which you...”). This question creates strong doubts as to whether the client really would have remembered the lab appointment. Once again the client’s response is reported as vague, as laughing “in a kind of funny way”. All in all the reported conversation formulates a negative portrait for the client when it comes to his rehabilitation prospects. His reported answers serve as evidence that he does not take the practitioner’s talk “seriously”, and will probably not manage with his timetables in the near future either.

The reported conversation with the client is presented in a way that creates it as an unsuccessful encounter. The interpretation of unsuccessfulness is to be read also in P1’s response, where she moves on to consider a solution for the problem at hand. Hence, the reported unsuccessful conversation serves as a ground for the coming conversations about what should be done with the client in the future. The conclusion is not that the practitioners should try to develop more successful conversations in order to responsabilize the client. Instead the practitioners start to create a solution that takes the client’s need for help with daily affairs into account. Given that the client will soon leave the course and should start living on his own, the

concern arises about how this will succeed. In her response to the reported client-practitioner conversation P1 puts this concern into words: “he would really need some home visit group there”. P2 and P3 immediately confirm this need in their aligning responses. In the following thorough solution formulation presented by P1, the reported conversation between Mattila (the municipal care manager) and P1 is used as a resource. P1 quotes Mattila, who had talked about a new psychiatric home rehabilitation service. P1 reports her response where she had mentioned the client as needing this service. In her response she had also constructed a conflict: the client himself disagrees or is probably not willing to accept the service.

From these two reported conversations and the (self-)evaluations linked to them the practitioners proceed to self-advising. If the practitioners assess that the client needs strong support, they should try to organize it somehow. The problem in this organizing is however the client’s assumed resistance. So, this resistance should be broken down before this service can be provided. Self-advising contains two tasks for the practitioners. Both tasks are in the form of future conversations. They should discuss with the client about the support option as well as inform the client’s treatment institution (his doctor) about the possibility.

## **5. Conclusion and discussion**

To conclude, our findings prove that the elements of assessment were present in the majority of the reported client-practitioner conversations presented and discussed in the backstage meeting talk among the mental health practitioners. Assessment making had three overlapping functions. The most common way was to make “practitioner-driven” positive or negative assessments of the clients on the basis of what they had said or how they had behaved in the reported conversations (the first function). However, some of the reported conversations were presented

and discussed so that the clients' self-evaluative prior talk was taken as important information and a starting point when assessing their situation (the second function). The practitioners also used the reported conversations as tools in their professional self-evaluation. They constructed failures in their prior encounters with the clients and gave advice to themselves about how to manage the future situations and conversations better (the third function).

By analyzing the assessment functions of reported conversations in informal backstage meetings we have demonstrated how everyday assessments are made in professional talk on such occasions where assessment is not recognized as the primary activity by the participants. Assessment is not merely separate professional practice, which is conducted with ready-made tools such as different tests often connected to (data-based) programs, standardized interviews, and forms. Assessment as everyday practices in the rehabilitation courses and in mental health work in general is certainly not reduced to reported conversations only. However, they are one powerful and frequently used "unnoticed" device in assessment making and thus worth studying and making visible in detail.

Previous studies in mental health have often approached assessment from the point of view of risk governance. Rose (1999: 262) claims that assessing risk has become extremely prevalent in mental health, to the extent that risk classifications have become "the means by which professionals think, act and justify their actions". Particularly standardized diagnostic procedures import on practitioners the requirement of constant risk assessment. Castel (1991: 282) views psychiatric diagnostics and assessment as being mostly based on previous documents and expert statements about clients, or on the results of standardized assessment methods instead of "the concrete relationship with a sick person". The three assessment functions of reported conversations which we have addressed reveal how the practitioners actually assess their clients from a wider, relational perspective. Thus reported conversations serve as an alternative view to

expert assessments focusing on the narrow notion of risk. By utilizing reported speech, practitioners actually base their assessment on a concrete relationship and on conversations with clients.

It should be remembered that it is not insignificant about what and how the practitioners talk about the clients among themselves in the meetings, since the assessments based on reported client-practitioner conversations can have consequences beyond the meeting context. Assessments accomplished in the meeting talk can be transported to other reporting contexts and are re-used for their purposes, like for the filling of official client assessment forms. Everyday meaning making processes can thus be transferred to and have an impact on “standardized assessment making”, which stresses the importance of acknowledging them.

The clients’ prior talk is strongly present in the reported conversations. Does this mean that the clients’ talk is taken seriously on the rehabilitation courses? Their talk is taken seriously in the sense that they are told to having been heard in “the original encounters” and are seen as producing important knowledge in the practitioners’ backstage meetings. The practitioners’ self-evaluations and the related advice also show that they sought to base their work on the clients’ assessed risks, needs, and abilities. However, the clients themselves are absent from the meetings and cannot comment on their and the practitioners’ prior talk in the reported conversations. The reporting speaker him/herself instead has this commenting power on both the client’s and his/her own prior talk. Furthermore, the other practitioners as the recipients of reported speech can join in making interpretations about the prior conversations. The absent clients do not have this option of re-interpretation.

The vivid descriptions of conversations with the clients and the ways they are discussed in the meetings tell about professional practice that is performed closely with the clients. Conversations are not just reported, but there is no doubt that the practitioners and the clients

have them frequently on the rehabilitation courses. Closeness to the clients might produce talk that lacks mocking and parodying nuances, which are often present in reported speech. Although the practitioners sometimes create negative portraits of the clients, the reported conversations are not stories that are told and shared in a similar way over and over again. Negative and positive portraits and assessments are not fixed.

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