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CHAPTER 9: NEGOTIATING BOUNDARIES OF PROFESSIONAL RESPONSIBILITIES IN TEAM MEETINGS

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Introduction

Legislation and organisational procedures regarding social and health care define the responsibilities of health and welfare workers. For example, decisions on hospital admissions are carried out by the psychiatrist in charge of the client, placements for supported housing are ultimately approved by the municipal commissioner and everyday face-to-face contact with the client is maintained by the support worker. Despite these official and apparently clear-cut duties, the operation of mundane care work often gives workers uncertainty regarding their roles and expectations (Thompson and Dowding 2001; Tainio and Wrede 2008). For example, Iqbal *et al.* (2014) report many unresolved debates on how mental health workers should proceed with their clients. Therefore, often responsibilities are ultimately shaped in everyday negotiations that Håland (2012: 768) characterises as "interactions that are not fixed and predetermined but that are dependent upon interpretations, discussions and contexts". Slembrouck and Hall (2014: 64) note that negotiations on boundaries of responsibilities take place in professional interaction where participants are sorting out "who will do what", and "who is, or should be, responsible for what". Scourfield (2015) calls this "negotiated reality", which refers to the ambiguity regarding who is responsible for making, implementing and checking up on various care decisions.

Responsibilities among welfare workers are complex within the fragmented service system (Clarke 2004; Möttönen and Kettunen 2014). Hence, it is likely that professional responsibilities may be differently defined and understood, resulting in negotiations between the different stakeholders. The notion of boundaries is useful in studying the division of responsibilities because it focuses on how social actors construct groups as similar and different and how boundaries shape their understanding of responsibilities (Lamont and Molnár 2002). In other words, as workers discuss their responsibilities, they come to define their own scope of practice in relation to those of others and to set boundaries concerning "our" tasks and expertise between those of "others". For example, Atkinson (2004) notes how physicians discursively construct their and "others" competence and responsibility in medical collegial talk.

We begin by discussing welfare workers' boundary negotiations in relation to risk management and their status as grass-roots level workers within a multiprofessional field of community care. Following this we introduce and develop boundary work as a frame for the analysis. By analysing welfare workers' collegial talk in team meetings, we focus on the ways they negotiate and justify the boundaries of their responsibilities in relation to those of collaborating workers from other organisations. The analysis concentrates on those instances of talk where welfare workers discuss their clients' situations that are changing in some ways and promotes talk about the responsibilities and possible risks involved.

Risk management in the core of boundary negotiations

The notion of risk is inherent in current welfare policies that are particularly inclined to "the questions of future predictability and controllability" (Borosch *et al*. 2016; Harrikari *et al.* 2014: 5). Particularly community care in England is identified as having a strong focus on risk management (Godin 2004; Joyce 2001; Stepney and Popple 2008), while the Finnish implementation of risk management is noted to be more moderate (Koskiaho 2014). However, policies in both countries pinpoint the gaps between services as notable risks that need to be prevented by more fluent collaboration between services (Schneider *et al.* 1999; World Health Organisation 2010). Thus collaboration as a means to manage risk in the fragmented service system can be seen to require increasing boundary negotiations among workers.

According to Kemshall *et al.* (1997), the responsibilities of managing risks are being relocated from the state to the delegated organisations in community care, which includes the margins of welfare services. The result of the relocation of risk management in the grass-roots level of community care is that workers have to adopt their own organisational processes of risk management (Kemshall *et al.* 1997). The same has taken place in various professional fields, where professionals are assumed to manage the increasing uncertainty and anxiety of a complex "risk society" (Beck 1992; Fenwick 2016: 57). Risk management has become a professional responsibility where each individual worker is obliged to calculate risks as central to their professional conduct (Joyce 2001; Miller and Rose 2008: 107–108). Welfare workers are extensively engaged with the issues of risks in their daily practices (Chapters 2 and 7; Parton 1996: 98; Godin 2004; Sawyer *et al*. 2009). Some risks relate more clearly to workers' own professional position. In these cases risk management is seen to ensure workers' personal safety and to fulfil their accountability requirements from their organisation's perspective (Godin 2004: 355; Sawyer *et al.* 2009: 367, 371).

Besides their professional position, workers are primarily expected to enable their clients to deal with several risks (Evetts 2003). These include the risks that clients might pose to themselves (Godin 2004) or those that they might pose to other people or larger society (Miller and Rose 2008: 107). Thus, workers are responsible for the advice that they give and the success of the interventions that they carry out to manage the risk (ibid.) Risk management is at the core of what Brodwin (2013: 68, 69) sees as the responsibilities of mental health workers: ensuring stability in clients' lives by keeping the client safe, within housing and out of institutions. In other words, as "agents of stability" (ibid: 66) workers are responsible for preventing crises in regard to psychiatric problems, residence or social relationships. Risks arise especially when changes of some sort take place in the client's life, such as when clients are transferred to another service or their well-being is deteriorating. As noted in Chapter 2, within these situations workers are held responsible in assessing the risks in terms of "high risk" situations; for example, when a client evaluated as suicidal returns home from the hospital. Workers are also responsible for "small-scale" risks, such as the client missing a doctor's appointment if not reminded by the professionals.

Both high and small-scale risks trigger boundary negotiations among workers, as we will see in the empirical section. Negotiations on professional boundaries are carried out regarding questions such as the following: how is it best to handle and respond to the changes in the client's life? Who will do what? Who has the competence to make recommendations and decisions? This need for workers to carry out constant negotiations on risks is in accordance with what Broadhurst *et al.* (2010: 1047)

call “informal logics of everyday risk management”. The welfare workers’ team meetings are one important arena for these mundane negotiations and are studied in this chapter.

Shifting professional boundaries in community care

There has been a widespread fragmentation of services in social and health care (Clarke 2004; Evans 2010; Möttönen and Kettunen 2014). In Finland, community care has traditionally been conducted by non-governmental organisations (Koskiaho 2014) while the recent developments in health and social care policies has brought private companies into the field (Tynkkynen *et al*. 2013; Chapter 10). In England around two thirds of the social care workforce is outside of the public sector (Kessler and Bach 2011: 86). In community care in particular, workers represent a wide variety of “multiple state and non-state players” (Scourfield 2015: 928) that are employed by private companies, public and semi-public service providers as well as non-profit associations.

At the grass-roots level of community care, professional boundaries are shifting as a response to an increased diversity of professional and voluntary stakeholders in the field. The boundaries of professional responsibilities have partly been blurred by the transition from hospital-based interventions to community care (Brown *et al.* 2000), where workers have various educational backgrounds and collaborate beyond the boundaries of their own occupational group and organisation (Chong *et al.* 2013; Mossberg 2013). The multiplicity of community care requires effective interaction skills from workers to successfully negotiate the responsibilities with others. At the same time, clients’ life spheres and the range of challenges they face are widening, requiring welfare workers to employ almost an all-encompassing orientation that takes into account the complexity of clients’ situations (Brodwin 2013). In this context the issue of boundaries becomes problematic in two ways: first, the functioning of welfare services is not limited to a single location but disperses around several organisations, and second, collaboration between inter-professional teams is noted to lack formal and mutually shared boundary structures (Brown *et al*. 2000). These issues relate to wider shifts taking place within inter-professional boundaries and the nature of the work undertaken by different health and social care professionals (Hopkins *et al.* 1996; Nancarrow and Borthwich 2005).

One motivation for shifting boundaries among welfare workers can be tracked to managerial systems and practices that have been developed to constrain the autonomy of public service workers

and to regulate their activities; not just measuring their performances but reorganising the whole basis of service provision. Whilst there is much debate about what constitutes the defining characteristics of a profession (Laffin and Entwistle 2000) and the extent of managerial surveillance, the contested status of workers in public services can be seen less about traits and more about relational characteristics. As Noordegraaf (2007: 774–775) puts it: "(…) this calls for interdisciplinary knowledge and interactive skills. Professionals know how to operate in organized, interdisciplinary settings that cannot be organized easily; they know that cases, clients, costs and capacities are interrelated". Noordegraaf calls such workers "hybrid professionals". They are flexible, able to move around systems, to adapt to changing environments and search for occupational identities. One example of workers' ability to cross boundaries is the flexibility with which they move between social and health issues, thus operating as "hybrid sociomedical workers" (Brodwin 2013: 56). In addition to employing both social and health orientations with their clients, welfare workers can be characterised as "hybrid" in the sense that besides mastering the contents of client work, they know how to portray their work as efficient for managers (Saario 2014). Likewise, hybrid medical professionals are found to possess management accounting expertise in addition to their more traditional clinical skills (Kurunmäki 2004).

Social workers are pivotal collaborators of welfare workers. In the development of community care, the social work role in adult services has taken on a pivotal role, particularly in England. As the state is less of a provider of services and commissions services from others, it is the social worker who is responsible for assessing need, purchasing services and managing packages of care, or as Malin (2000: 12) says acting as "a broker". In some municipalities the name has changed from social worker to care manager. Lymbury (2000: 134) considers that the key boundary issue is the effect on the social worker's relationship with the client. He considers having taken on largely technical responsibilities, with the centrality of developing an in-depth relationship with the client been reduced. Indeed, the social worker-client relationship is "unnecessary, even distracting", as the key task is gathering information "to make a categorization on which a subsequent purchase is made" (Lymbury 2000: 134). Also, in Finland the role of a social worker is noted to be increasingly that of a designer, manager and coordinator of service processes, whereas less educated social and health care workers conduct the actual face-to-face community care work with clients (Sarvimäki and Siltaniemi 2007: 40–42).

Community care is noted to signify new territories for paramedical and associated professions, such as welfare workers who are able to colonise new spaces to operate; for example, home visiting

(Prior 1993). Thus the retreat of the social worker from the caring role has opened a space for the welfare workers as providers of care and support. Malin (2000: 15) highlights the influential Griffiths Report (1988: para. 8.4) which suggested the creation of "a community carer" to undertake "the front-line personal and social support of dependent people". Such workers should provide "assistance required without demarcation problems arising". In other words they should be flexible and not bound to professional allegiances. The number of welfare workers, such as care workers and support assistants, has increased significantly over the last 15 years (Kessler *et al.* 2006), who are often under the direction of more highly educated staff (Nancarrow *et al.* 2005).

Whilst housing support workers have been employed by municipalities (and housing associations in England) to enable vulnerable clients to maintain their tenancy, the extension of support for clients with special needs is relatively new. As discussed above, the housing support worker has characteristics similar to assistant roles created in the community care policies. They visit clients regularly in their homes (between 1 and 3 times a week) and work to support plans covering everyday tasks concerned with health, employment, recreation, medication, personal and social skills, notable budgeting and tenancy maintenance. As Cameron (2010: 102) notes, "a role which previously might have been provided by a social worker or probation office". An essential part of these tasks is managing the risks involved and assessing who is responsible in which situation.

Analysing workers' negotiations on boundaries

Due to welfare workers' grass-roots position in community care, their involvement in risk management and shifting responsibilities are essential to study from the point of view of professional boundaries. Focussing on workers' team meetings, the empirical analysis examines especially how workers of non-governmental mental health organisations define their responsibilities in relation to other professionals in the field. Most workers have vocational qualifications in social and health care while some have undergone training with no degree. They work for two services: 1) the first is an English floating support service for people with mental health problems; the workers collaborate mostly with their clients' care coordinators and services providing home care or medical assistance for their clients; 2) the second is a Finnish project offering housing and social skills training for young adults with diagnosed schizophrenia; the workers collaborate mainly with psychiatric outpatient clinics, social services, other supported housing and daytime activity schemes. As inter-professional and inter-agency collaboration is an essential part of work, the services are ideal contexts for studying boundaries of different

responsibilities. Further demands for collaboration are set by their "half way nature": services provide support only on a relatively short-term basis (from a few months to around a maximum of 2 years) and thus deal with frequent client transitions where they collaborate both with the services from where the clients are coming and those to where the clients are heading.

Boundary work is closely intertwined with professional responsibilities, for example Allen (2000) considers boundary work to entail negotiations on the division of responsibilities. Boundary work involves a demarcation of insiders and outsiders (Lamont and Molnár 2002). From an interactional and discursive perspective, Juhila and Hall (Chapter 4) describe boundary work as a situated practice where professional and organisational demarcation is carried out, including (re)negotiations of responsibilities. In a similar vein, Slembrouck and Hall (2014: 62) refer to boundary work as the ways in which workers and clients manage "the dilemmas of the personal, professional, organisational and cultural divisions during everyday encounters". In this chapter, we concentrate on the accomplishments of boundary work where workers differentiate themselves from others on the basis of their particular responsibilities. These can be termed as discourses of competence which are tied to the evaluation of others' and the speaker's own knowledge, opinions and actions (Atkinson 2004: 13).

As a regular part of professional work, team meetings are ordinary everyday practices where workers' talk can be analysed from an ethnomethodological perspective (Garfinkel 1967). Viewed as interaction of a group of workers with more or less equal tasks, meetings can be analysed as joint negotiation on the responsibilities of the team members and those outside the team. We approach the negotiation of responsibilities as a process by which boundaries, demarcations or other divisions are constructed (Wikström 2008: 60). A useful analytical concept for this approach is boundary work, which was introduced originally by Thomas Gieryn (1983). Boundary work frames our analysis by recognising talk on boundaries as discursive negotiations, as pointed out by Riesch (2010). There is always a goal in boundary work; in this case to sort out the responsibilities.

When analysing workers' negotiations as boundary work, we look at the ways they produce justifications for workers' own and other's responsibilities. Justifications are accounts or statements given "to explain unanticipated or untoward behavior" and to neutralise the behaviour or action and its consequences (Scott and Lyman 1968: 46, 51). We aim to use justification to demonstrate a two-fold construction of boundaries. First, workers delegate responsibility to others, with the rationale "this does not belong to us since it demands other kind of skills than ours". In other words, they

exclude responsibilities that do not belong to them. This is called exclusionary boundary work in Chapter 4. Second, assuming more responsibility for workers themselves draws on the notion that "this belongs to our domain of work because we have the skills, thus we are the ones that can best support the client". In Chapter 4, this is called inclusionary boundary work. In the analysis, we view inclusiveness and exclusiveness from the workers' perspective, i.e. how they jointly talk about excluding themselves or including themselves in particular situations of clients ─ not how they exclude or include others.

Team meetings are occasions for workers to carry out collegial talk by discussing the latest developments of the clients within the current case load. Furthermore, the meetings enable the planning of subsequent interventions. The familiarity of team meetings makes them particularly important occasions for boundary construction as workers can freely address and even question the boundaries between theirs and others' responsibilities and forms of expertise. The informality of team meetings is partly due to their "backstage" nature with no audience (Goffman 1990). Questioning expertise of others would probably not appear "at the front stage" i.e. wider meetings with outsiders − such as managers, collaborators or clients. The meetings can be described as arenas for informal talk that allow straightforward conversations and upfront descriptions about absent parties such as clients (Juhila *et al.* 2014a: 166; Urek 2005) or workers from other agencies (Saario *et al.* 2015).

In the forthcoming analyses we present four examples of floating support and project workers' joint negotiation on boundaries of responsibilities. Each example features a particular responsibility: 1) the responsibility of maintaining contact with the client; 2) the responsibility of maintaining an adequate level of support; 3) the responsibility of safeguarding the client's future; and 4) the responsibility of informing one's own professional view for collaborators. In each example workers discuss a case where a change is currently taking place in the client's life. We assume that changes in the client's situation promote talk about responsibilities and possible risks more often than stable situations (see also Scott 1997). We pay special attention to how the boundaries of responsibilities are justified and negotiated among workers concerning specific client cases.

Exclusionary and inclusionary boundary work

Negotiating boundaries of responsibilities when maintaining contact with the client

The first team meeting extract is from a floating support service in England. The client discussed in this example is a woman in her thirties who is visited at home by the floating support (FS) workers three times a week. Her wellbeing is acutely challenged due to her hearing voices and her refusal to let the workers into her home. In the meeting, maintaining contact with the client in this changed situation arises as the key professional responsibility.

In this extract, FS workers bring up two other parties with whom they collaborate. First is the Crisis team that specialises in clients with urgent and severe mental health problems. They usually become involved when intensified and specialised psychiatric home treatment is required. Second is the client's care coordinator from the local psychiatric outpatient clinic, who is a community psychiatric nurse (CPN). FS workers are in a regular contact with the CPN regarding the client's care plan, overall situation and especially now that these problems have arisen. Worker 1, who is chairing the meeting, initiates the discussion on the client by stating her initials.

Extract 1.1

1. WORKER 1: WM.
2. WORKER 2: A bit of a crisis on Tuesday with her. I rang her about her review, she was supposed to have her review on Tuesday, and she was screaming down the phone, tried to speak to her and she wouldn't communicate with me at all. Rang Crisis, they didn't want to know because it was nearly nine o'clock. Spoke to her CPN and we went out at 10 o'clock and she's shaved all her hair off, her eyebrows off, wouldn't speak to us, was writing stuff down for us saying that a male voice wouldn't let her talk. But he ((the male voice of the client)) spoke to us saying that he didn't want to harm her, he just wanted to make her suffer. CPN rang Crisis and they said that we were fine to leave her because her voice said that she was going to be safe, because it wasn't going to hurt her. Crisis went out and seen her Wednesday morning, then she refused to let them in Wednesday afternoon, they wouldn't have any contact with her. And then they went back out yesterday morning and she let them in, but she's still not talking. I've tried contacting her myself a couple of times during the week, but it seems that she's unplugged her phone from the wall, so I can't get through to her.

Worker 2 starts describing the intensified and changed situation of the client by reporting a phone call with the client who would not communicate with her. She uses the client's unwillingness to speak to her as a justification for consequent requests for other professionals to come on board.

First, she rang Crisis which declined the request on the basis of the time of the call: in office hours the primary professional to be contacted is the care coordinator. Here, exclusionary boundary work takes place as the responsibility for maintaining contact with the client is directed to workers of other organisations than floating support.

After speaking to the CPN, worker 2 visited the client together with the CPN suggesting that worker 2 does not completely exclude herself from this responsibility but rather shares it, although we do not know how far the CPN or support worker directs this visit. Worker 2 then reports her observations from the home visit to indicate the severity of the situation: the client has shaved her hair off and hears a voice that denies her to talk to the workers, so the client communicates with the workers in writing. At the site, the CPN contacts Crisis and receives permission for herself and worker 2 "*to leave*" the client. Crisis is heard to justify such an assessment as the client's voice indicates that she "*is going to be safe*" which is considered to indicate that she would not hurt herself. So Crisis is portrayed as the agency responsible for the consecutive home visits and for maintaining contact with the client as is justified by the severity of the situation.

In the last three lines, worker 2 assumes some responsibility back by reporting that she has been trying to contact the client by phone, although without response. The phone calls were carried out despite Crisis being responsible for maintaining contact with the client. The calls can be interpreted as a caring attitude and concern of FS workers towards the client. By trying to reach the client "voluntarily", FS workers are doing an extra bit beyond their current responsibility, which can be interpreted as an attempt to justify FS workers' role with the client as still important even though others had assumed responsibility for decision-making. The meeting continues by the dialogue between the two previous speakers and worker 3.

Extract 1.2

3. WORKER 1: Right.
4. WORKER 2: But Crisis are dealing with it and they're going to let us know.
5. WORKER 1: What do you think is usually the outcome of this kind of thing, is it like admittance to hospital or?
6. WORKER 2: It depends.
7. WORKER 1: Right.
8. WORKER 2: We've got to wait to see what Crisis do, it's up to them to make the decision, not us.
9. WORKER 1: And they're getting in touch with us when they're.

10. WORKER 2: They'll get in touch with ((the care coordinator)) who should be getting in touch with me.
11. WORKER 1: Right.
12. WORKER 2: Which is what's been agreed but.
13. WORKER 1: If that doesn't work out obviously just give them a call.
14. WORKER 2: I ring them every day anyway.
15. WORKER 1: OK, that's all right then. Not much we can do if it's like that.
16. WORKER 2: There isn't anything we can do, just keep trying to contact her.
17. WORKER 1: OK, it's not worth going out is it?
18. WORKER 3: No.
19. WORKER 2: No, we're not allowed to.
20. WORKER 3: We're not allowed to when she's unwell because of previous risks.
21. WORKER 1: Obviously that's Crisis' job.
22. WORKER 2: Yeah, because her voice wanted to kill me before.
23. WORKER 1: Right, well that's fair enough.

This extract continues to demonstrate joint accomplishment of exclusionary boundary work on the basis of which FS workers terminate their home visits for now. The responsibility of maintaining contact with the client is justified by the active involvement of Crisis who are now "*dealing with it*" and "*going to let us know*" as worker 2 says (turn 4) after being affirmed by the chair. Thus the floating support service is positioned as awaiting Crisis' contact. In turn five, the chair introduces another possible intervention besides home visiting and asks others' opinion regarding the likelihood of the client's admission to a psychiatric hospital. Worker 2 sees this also as Crisis's duty: "*it's up to them to make the decision, not us*" (turn 8). The chair confirms this by saying that Crisis will inform them by which worker 2 specifies in more detail that FS workers will hear from Crisis through the CPN "*who should be getting in touch with me*" and thus delineating a longer chain of responsibility. Worker 2 uses the formulation "*should*" which might infer a slight uncertainty about whether this will happen. The uncertainty becomes obvious also in turn 12 where worker 2 displays the current state of affairs (without anyone asking) "*which is what's been agreed but*" which also repeats the justification for exclusionary boundary work of FS workers. In turn 13, the chair takes back some responsibility by giving advice on how to proceed: if they do not hear from the CPN they will call her. The chair is extending FS workers' responsibility from the previous position where they merely await contact from others. If the CPN would not fulfill her responsibility of contacting the floating support, FS workers will contact her on their own initiative: "*obviously just give them a call*", by which they might want to make sure that the CPN handles the situation as agreed or that they are not excluded from future decisions. Worker 2 however neutralises this into ordinary action by stating that she will call them "*every day anyway*". In turn 16, worker 2 demonstrates FS workers' simultaneous exclusion and inclusion of their

responsibilities which are inconsistent: "*There isn't anything we can do, just keep trying to contact her*". In summary, the negotiated boundaries can be characterised as mainly exclusionary, as this indicates a narrower responsibility compared to FS workers' usual responsibility of carrying out regular home visits.

From turn 17 onwards, exclusionary boundary work is accomplished again and is now justified by risk. The workers jointly narrow their responsibility of "*going out*" to meet the client because of the concern for their own safety. In turn 20, worker 3 relates the risk to organisational risk aversion guidelines: FS workers "*are not allowed*" to do home visits "*because of previous risks*", thus indicating an external procedural constraint on possible action. They may face sanction from their own organisation if they attempt a home visit in such circumstances. The chair confirms once again that contacting the client is "*obviously*" "*Crisis' job*". Worker 2 agrees and specifies the type of risk on the basis of her history with the client: there has been an incident where the client's voice threatened to kill her. In the light of this risk, home visiting is not even an option for FS workers. This echoes the findings of Sawyer *et al.* (2009: 367) on mental health workers following risk management procedures both to ensure their own security and to fulfill accountability requirements from their organisation's perspective.

Extracts 1.1. and 1.2. can be described as "*action-oriented boundary work*" (see Slembrouck and Hall 2014: 70) where maintaining contact with the client is recognised as a responsibility that must be fulfilled by doing something; often resulting in negotiations on who will do it, FS workers or someone else. The workers repeatedly use verbs that indicate the responsibility of other services. They exclude themselves from this responsibility, as well as from the decision of whether to start preparing the possible hospital admission. However, the exclusion is justified by them having passed on concerns appropriately to other, specialist professionals as they can now be assured that the client is now being taken care of.

Negotiating boundaries of responsibilities when maintaining adequate support

In the next extract a change has taken place when the client returns home after being discharged from the psychiatric hospital that presupposes that the "test" weekend at home goes well. The situation is the opposite of the previous example in the sense that here the client, a woman in her forties, is getting better and her delusions have dramatically reduced. The workers are from the same English floating support service and are now negotiating responsibilities that concern

providing an adequate amount of support. Boundaries of responsibilities are negotiated between the CPN's office, the psychiatric hospital, the home care and the supported housing unit/floating support service. Worker 1, who is chairing the team meeting, initiates the discussion by stating the client's initials and telling about the client's CPA meeting.

Extract 2

1. WORKER 1: PM. We attended, Mary ((Worker 3)) and I attended the CPA last week. It was noted that her delusions had dramatically reduced. She was getting loads better wasn't she basically, was what they said.
2. WORKER 2: Yeah.
3. Worker 1: She's not as unwell. She was going on home leave for that weekend, and had ((domiciliary service)), was it?
4. WORKER 2: Yeah.
5. WORKER 1: Going in four times a day, and Crisis team was it that were going in as well over the weekend to make sure she was coping okay at home. Providing everything went well, which I'm assuming it did, she is being discharged from ((psychiatric hospital)) today. It was said that we ((floating support)) will still attend for one hour a week on a Friday, but we don't feel that's enough. I think I said this to you last week didn't I, an hour is not enough so we need to kind of get in contact with.
6. WORKER 2: Jennifer.
7. WORKER 3: Who?
8. WORKER 1: ((care coordinator)).
9. WORKER 2: Or ((substitute for the care coordinator)).
10. WORKER 3: Yeah.
11. WORKER 1: Yeah, to kind of up her hours and give her two hours back.
12. WORKER 3: Two hours' support a week.
13. WORKER 1: Because an hour's not long enough, so we need to try and get another hour put in place, so she can have the two hours on the Friday. She's on quite a high dose of, I never remember medication.
14. WORKER 2: Quetiapine?
15. WORKER 1: Quetiapine, that's the one, she's on quite a high dose of that, but I think home care are going to be dealing with all that aren't they, they said they were going in quite a lot so. And basically ours is just community access.
16. WORKER 2: Yeah, getting her out and about, yeah.

In turns 1–5, the workers report previous developments with the client, how other professionals have been involved and how they have evaluated the clients' improved condition. Consequently, the client was discharged from the hospital. In the end of turn 5, worker 1 continues to report how others had made a decision and what "*was said*" about their role in the client's care: "*we ((= floating support*)) *will still attend for one hour a week on a Friday*". She does not accept this as they should be more involved. The workers are promoting their role and importance in this case by contacting the care coordinator and trying to get back two hours support for the client, which had

been the case before. The workers' talk reflects the inclusionary boundary work as they need to be more involved. Nevertheless, they are not explicitly explaining why they need to get that one hour back, except that two hours was the amount of hours before the hospital period. In turns 13–16, the workers note the high dose of medicine the client is taking and exclude themselves from dealing with it as it belongs to the home care's responsibility. The increased amount of floating support might be implicitly justified by the high dose medication: although worker 1 does not directly connect these two, she first states that the client "*can have two hours on the Friday*" and continues by noting the high dose of medication. As such a high dose is needed, the client also requires her hours doubled in order for FS workers "*getting her out and about*". The high dose of medicine might indicate the risk of the client remaining isolated in her home.

This extract from the team meeting demonstrates mostly inclusionary boundary work, as the workers assess that they need to include themselves more in the client's case than has been proposed by the others. This example represents action-oriented boundary work (Hall and Slembrouck 2014) as there is talk about who should do certain things (take care of medication) but also authority-oriented boundary work as there are negotiations about who has the authority to decide their contribution to the client's care in the future. By "authority-oriented" boundary work we mean those who have the right to decide and whose professional opinion is taken seriously by others, thus differing from action-oriented boundary on who will do what (see Hall and Slembrouck 2014). In the end part, the boundaries are more negotiable and exclusionary (medicine taking) in relation to their expertise. All in all, the extract demonstrates the functioning of a home visit as a key vehicle for monitoring risk (Broadhurst *et al.* 2010). The responsibilities of managing the risk of isolation are negotiated by considering both social and medical issues, in other words, by employing "hybrid orientation".

Negotiating boundaries of responsibilities when safeguarding the client's future

In the third extract we present meeting talk about the client, a man in his early thirties who is currently living in the Finnish project that offers supported housing and social skills training for young adults with diagnosed schizophrenia. The major change around which the discussion revolves is the client's upcoming transition as the project is ending, and there is a need to find alternative supported accommodation. The project workers' task is to evaluate the options for supported housing or floating support based on the assessment they make during the project. Instead of an official decision, they only make recommendations for the formal decision making carried out

by the commissioner and the psychiatrist in charge. The key responsibilities discussed concern communicating the current status of the client's ill-health and mundane living skills so that other professionals can safeguard the client's future. There are a total of four project workers in this particular meeting, but in this extract, three of the workers are talking about arranging a network meeting for the client. Worker 1 comments on the idea of inviting the home rehabilitation team to the meeting.

Extract 3

1. WORKER 1: I think we probably should ask them ((floating support)), because we are a bit, when we were talking they didn't actually have a clue that Tom even had these terrible delusions.
2. WORKER 2: I was just thinking the same when Mia ((worker of floating support)) popped in there, to ask something, she just said that oh he was such a funny guy, this Tom.
3. WORKER 3: Yeah, a lovely guy with such good stories to tell.
4. WORKER 2: And also Maria ((another worker of home rehabilitation team)), I was there just for a little while, but anyhow when Jan ((worker from the project)) said that we have thought that it is really hard for Tom to live independently, well Maria was genuinely surprised by that, like really, why would you think that?
5. WORKER 1: No way, oh my goodness. Really, that's horrible.
6. WORKER 2: There's the thing as well that before Tom has used his car to get to places, but now he has realised himself that he doesn't really, like there's stuff like he cannot drive on bridges for example, and now he has understood to leave the car completely.
   ((Removed: talking about the past when the client was still driving))
7. WORKER 1: Well this really must be initiated, I think, bit by bit. Now he has all the necessary information, at least regarding how to live at home and how, how important it is to have a kind of regular rhythm so that it doesn't go to that, and then all these arrangements and controls and visits but, we'll see it in the follow-up period that whether this works or not, and then I think we should collaborate with these, you know, these.
8. WORKER 2: We could ask the home rehabilitation team.
9. WORKER 1: The home rehabilitation team and, these people, ((client's nurse from the psychiatric outpatient clinic)) or what was the name.
10. WORKER 2: Would they come then, and the home team ladies ((refers to home rehabilitation team)) and possibly the GP into the same meeting where we could state the situation what we think is going on, and then we have, in my opinion, kind of transferred this bit to them. You know all these things like measuring blood sugar levels and all, I mean if he will be having insulin so someone should visit there, home-based nursing services to give that medicine to him. Plus that pill dispenser, it's in a right state, oh my god.
    ((overlapping speech))
11. WORKER 1: Yeah both the care of the psyche and the physics, it all depends on Tom really, well that cannot work out like that.
    ((Removed: discussing available dates for the network meeting))
12. WORKER 1: Yep. We could offer a date ((for the meeting)) because apparently it seems unclear for quite many ((people)), for example the psychological condition of his, that how much he has these delusions and fears in the end.

In the beginning, worker 1 justifies the need to involve the rehabilitation team in the network meeting with other collaborators that she poses as lacking relevant, up-to-date knowledge about Tom: "*they didn't actually have a clue that Tom even had these terrible delusions*". Then workers 2 and 3 confirm this by using reported speech (Holt and Clift 2007) of another worker (Mia), which also demonstrates that the collaborator is not up to date with the seriousness of the client's condition. In turn 4, there is a reference to another worker Maria who has the same kind of misunderstanding and lack of knowledge about the situation: "*Maria was genuinely surprised by that, like really, why would you think that?"* There is also a reference to their colleague Jan's evidence of Tom's difficulties to live independently. Then worker 1 assesses the situation with criticism and upgraded terms: "*no way, oh my goodness. Really, that's horrible*" which is evidence of backstage talk shared by "insiders" (Goffman 1990). Thus, the project workers separate their competence from other collaborators as they are holding the "*everyday evidence*" (Saario *et al.* 2015) of a client; while collaborators are presented as lacking this knowledge. Inclusionary boundary work is based on everyday evidence to influence the decision on the most appropriate living arrangement for the client (see also Scourfield 2015).

In turn 6, worker 2 describes how they are up-to-date on the seriousness of the client's situation and have clear evidence that Tom is not capable of e.g. driving. Here, worker 2 establishes Tom's incapability to drive as a fact based on evidence that is outside the worker's own subjective assessment. The establishment of factual evidence (Smith 1978) is strengthened by the positive side that also the client himself has realised this problem. Thus, worker 2 justifies their everyday evidence by encouraging collaborators to see the seriousness of the situation. On turn 7, worker 1 describes how they have succeeded in rehabilitating the client, and with this she also justifies the exclusionary boundary work: we've performed our responsibility to train the client regarding everyday skills and we will follow-up on this. This is confirmed in turns 8 and 9: the exclusion will be actualised by asking the home rehabilitation team and psychiatric nurse to the network meeting. Overall, the workers' talk replicates the need to update other collaborators regarding the serious mental ill-health of the client. In that sense they need to be included alongside other collaborators.

In turns 10 and 12, worker 2 summarises the possible future participants in the network meeting. Thus, her talk reflects the exclusionary boundary work: as they are handing the overall responsibility to outpatient clinic, another floating support service and GP. It also includes a suggestion to recruit a new service, home-based nursing service as there is a need for health care expertise with the medication and measuring of blood sugars. In turn 13, worker 2 furthermore

justifies the exclusionary boundary work as the network meeting needs to be organised so that other parties can be brought up-to-date regarding the serious mental ill-health of the client.

This team meeting talk is interesting as it demonstrates different justifications for boundary work from the previous example. Here inclusionary boundary work is justified by others not being up-to-date on the client‘s condition and ill-health. Now, as the client is leaving from the service, workers need to include other workers and also themselves in the network meeting in order to transfer the everyday evidence (helplessness, ill-health and need for support) to other collaborators. They want to ensure that their ways of thinking are adopted by other collaborators so that in the future their assessments will remain definitive of Tom’s problems. By doing this, they are managing the possible risks regarding the client’s situation in the transition process. The risk assessment and inclusionary boundary work is needed to communicate the situation in order to transfer the client properly and with enough support. Knowing the “client’s best” also functions as a justification for inclusionary boundary work. This extract represents the authority-oriented boundary work as it is associated with assessing who has the most relevant knowledge and competence on the client for the basis of the decision on the future support.

Negotiating boundaries of responsibilities when informing workers’ opinion to collaborators

Our last extract is from the same Finnish project as extract 3. The responsibility that is negotiated concerns the communication of the project workers’ opinion to collaborators. Prior to this extract, the workers discuss the client changing constantly his mind about where to live and what to study. Worker 4 (not talking in the extract) has said that the last time when she was talking to the client, he was not interested in moving to supported housing. In the previous turns, four project workers have been talking about the meeting that was held between the client, his parents and the municipal authorities and the social worker. In this extract they continue to talk about the meeting and wonder why they were not invited.

Extract 4

1. WORKER 1: I dunno how they’ll ((municipal authorities and the social worker)) take this idea of ((vocational training course)), in this Tuesday then, it’s in bits and pieces, the whole thing with Eric is not being considered very client-centric manner, from their part. Money matters. The scariest thing is Eric’s wellbeing, that’s how long will it take until his self-destructive thoughts arise again, although in the latest common meeting it was discussed, his self-destructiveness in general, that it’s bad and poor and what’s more,

and Eric brought up himself that it has now improved while he has been ((in the project)) that he has gained self-confidence and cleared his own thoughts, he can now trust them ((his thoughts)) and doesn't have self-destructive thoughts, well we'll see how all this messing up affects him now.

2. WORKER 2: It would have been so important that someone from us would have attended that meeting where the social worker was and.
3. WORKER 1: That's right, why weren't we asked.
4. WORKER 2: Yeah exactly, well our presence would have been very important and especially as Eric is confronted with such high expectations, like you'll start studying and into the working life plus all the hobbies on top of that.
5. WORKER 1: And independent living and.
6. WORKER 3: I asked about this.
7. WORKER 2: So awful.
8. WORKER 1: Why weren't we asked, why wasn't Nina ((occupational therapist of project)) or somebody invited. But somehow, what was the answer you got from Nina?
9. WORKER 3: Well, as this is not, well not about Eric alone but this is a kind of family counselling, so it is among them only and thus we don't go there, anyhow.
10. WORKER 1: We don't, we don't, but if they are having family counselling for this couple well why they rummage all these.
11. WORKER 3: Yeah, my point exactly that why it has become all about discussing Eric, this.
12. WORKER 1: Yeah, Eric being in ((this project)).

In turn 1, worker 1 quite strongly evaluates other collaborators' (municipal authorities and social worker's) involvement in Eric's case as not being client-centric. Other collaborators' actions have caused concern that the client's condition may possibly get worse. Worker 1 justifies this by reporting the client's thoughts about his condition and how it was much improved in the project. The worker is wondering whether this is now threatened because of "*all this messing up*". Her/his talk implies quite a high risk of the client's situation getting worse and also as justification for inclusionary boundary work: we have managed to support the client so that he is getting better; hence our views and involvement are essential in preventing the risks. They possess evidence of the client's improvements and would present contradictory views of other parties, which negatively affect the client's wellbeing.

In forthcoming turns, the workers are wondering why they were not invited to the meetings with social service authorities and thus not involved. They give justifications for inclusionary boundary work; as their presence and involvement in the meetings would have been important or very important, as other parties had set far too high expectations for the client. They report how they had asked why they were excluded from the meeting and what kind of answers they were given. In turns 10–12, the workers jointly justify the importance of their involvement as they do not accept that the

other parties would have talked about issues in the meeting that concerned them and their responsibility. Eric's involvement in the project should not be on the agenda of such a meeting.

This extract represents mainly authority-oriented boundary work, as there is constant negotiation of who has the relevant knowledge and competence regarding the client and decisions to be made about his future. The workers' dialogue displays backstage talk (Goffman 1990) that enables them to criticise other collaborators and their judgements. This extract illustrates the risks related to overly fixed professional boundaries, as workers need to promote clients' wellbeing and at the same time they need to argue for their competence and involvement of other collaborators. Hence, inclusionary boundary work is carried out to justify the team's further involvement in the client case.

Conclusion and discussion

Our discursive analysis supports the notion that boundaries are a pervasive feature of most professional practices and especially essential when professional responsibilities are negotiated (Allen 2000: 338–339; Hall *et al.* 2010: 349; Slembrouck and Hall 2014: 78). Boundaries are constructed in interaction (Hernes 2004) as workers communicate their specialties and restrictions to themselves and others. In team meetings, professional boundaries are mutually talked into being and negotiated in interaction, thus representing "a joint endeavor" of workers (Juhila *et al.* 2014a). For example, in the meetings the word "we" was frequently used instead of "I", and silent workers uttered constantly affirmative words like "yeah" to the speaker (these minimum responses were not transcribed in the extracts). Workers' team meetings can be seen as arenas for collective accountability, which indicates the sharing of responsibilities among the team members (Bell *et al.* 2011). To cite Lamont and Molnar (2002: 171), workers' collegial talk in team meetings reveals "with what kinds of inferences concerning similarities and differences groups mobilize to define who they are".

In this chapter we presented four examples where workers are negotiating the boundaries of their responsibilities in situations when their clients are undergoing particular changes that indicate increased risk. The responsibilities include maintaining contact with the client and providing adequate support, safeguarding the client's future and informing collaborators about workers' up-to-date knowledge of the client case. By using boundary work as an analytical concept, we found that

workers' and collaborators' responsibilities are talked into being by two distinct forms of boundary work: action-oriented and authority-oriented. Action-oriented boundary work (Slembrouck and Hall 2014) featured mostly in the first two examples where workers negotiated boundaries for the provision of adequate support and maintaining contact with the client. Both were recognised as tasks that require action and specific interventions from the workers or their collaborators. Authority-oriented boundary work, on the other hand, was prevalent in the two last examples on safeguarding the client's future and informing collaborators about the opinions of the workers. Workers mainly depicted others as not acting responsibly, while at the same time they justified themselves as experts in the clients' situation. Authority-oriented boundary work drew strongly on open criticism towards collaborators, to the extent that the meeting talk can be occasionally seen to include what Dingwall (1977) termed as atrocity stories.

In addition to authority and action -orientations, boundary work entails also exclusionary or inclusionary dimensions that have ethical implications. This echoes with Slembrouck and Hall's (2014: 74) notion on boundary work having both enabling and constraining effects at the same time. Constraining issues relate to what we call exclusionary boundary work. This raises the question of whether the tightening of resources and discourse of efficiency produce unwanted welfare service areas or client groups, which professions redefine out from their expertise. Even though not evident in team meetings, exclusionary boundary work is important to analyse as it might produce client groups that are not recognised as belonging to a specific expertise of any professions or organisations or who are easily referred to other welfare organisations (Chapter 4). This points out the challenging situation of the margins of welfare services that are often places of last-resort where workers cannot draw strong boundaries regarding the client selection yet need to include also "difficult cases" to their caseload. Exclusionary boundary work is also used to responsibilize collaborators by delegating duties to them. Inclusionary boundary work, on the other hand, relates closely to the enabling effects of boundary work (Slembrouck and Hall 2014: 74), as it involves workers self-responsibilizing themselves to take on more responsibilities and occasionally to go "the extra mile" (Doel *et al.* 2010). The workers construct themselves as a team drawing on the ethos of care and concern towards their clients. In both cases, responsibilisation is mainly carried out for the benefit of the client, for example arranging the most suitable form of support. The way workers negotiate their boundaries reveals that their specialty lies within mundane observations based on their assessments on clients. By sharing everyday life with clients they become familiar with the client's current wellbeing and needs as opposed to collaborative professionals that see the client more rarely and are more distant.

In sum, the analysis of boundary work among welfare workers operating at the grass-roots level indicates a change in the division of labour in community care: to advocate their clients, welfare workers carry wide-ranging responsibilities towards them. Instead of limiting their professional interventions to everyday support, they engage in frequent negotiations to advocate and even coordinate the care of the clients. Furthermore, boundary work in changing client situations illustrates risk management strongly as a negotiated activity (see also Allen 1997). Informal processes of shaping boundaries and related decisions, carried out in team meetings, pose a risk as an everyday issue that workers need to take into account, especially regarding the future of clients. In this light, risk management becomes understood more widely than as merely a set of standardised tools such as "tick-box" forms or recording artefacts that workers use to assess and manage risk (see Godin 2004; Juhila *et al.* 2014b). While formal tools are an effective way to display transparency of professional action, risk is eventually managed in face-to-face occasions within a relatively informal atmosphere − such as team meetings.

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