

voices from the frontline

Working with Josie: swimming against the tide

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Introduction

This is an exploration of daily mental health social work practice, considering specific relationship-based, feminist, systemic and political aspects of my work with service-user Josie¹ while children's services were involved with her child. It considers the extent to which it is possible to work collaboratively with someone, from a critical, feminist perspective, while functioning within the broader, day-to-day organisational systems of health, social care and the law that are often oppressive and re-traumatising. It outlines the work undertaken at a specific turning point in the work with Josie when her daughter, Alice, was made subject to child protection procedures (Children Act 1989, amended 2004), having previously been a 'child in need' (CIN) (Children Act 1989, amended 2004). This decision was made, in part, based on perceptions around her mental health, with the effect that the mental health and children's services spheres of social work were significantly entangled.

I consider the various and different ways in which both Josie and I sought to navigate these structures of power and their effects on both of us. In analysing my practice, I consider, in particular, my continued work as her mental health social worker during a time of changing goals and expectations (Josie's, her family's, those of children's services and those of mental health services). I explore the Care Programme Approach (CPA) process at this time and the mental health service care planning decisions made. I use systemic thinking to explore the social, cultural and political contexts in which Josie lived and that I worked within, and seek to understand the implications of these for the decisions that I made in practice. The professional and organisational context to the work is considered throughout. I conclude by considering the ways in which understandings of child protection social work and mental health social work might be reconfigured to allow greater scope for critical and radical social work in practice.

Introducing Josie

Josie is a white British woman with whom I worked for well over a year when she was in her early 20s. I was her mental health social worker within a Community

Mental Health Team (now called a Recovery Team), a multidisciplinary, integrated statutory team working with those who have a 'severe and enduring mental illness'. The team was based in a small town in England that has relatively high levels of social deprivation. I am also a white British female, was in my early 30s at the time, was not yet a parent and am originally from a similar social background to Josie. I have not, however, ever had personal involvement with statutory mental health or children's services, and my educational and subsequent financial experiences have significantly altered my relationship to my social background.

During the time that I worked with Josie, she lived variously in social housing and emergency and temporary accommodation, together with her younger sister, Laura. Laura often acted as her carer and I worked closely with them both. Advocating for ongoing housing and financial support for them was a significant part of this work. Both Josie and her sister, Laura, are defined in specific policy terms as young people Not in Education, Employment or Training (NEETs) (DCSF, 2008), have no formal qualifications, suffered significant childhood trauma and abuse, and have lived in relative poverty throughout their lives. Josie became a parent as a teenager and has had varying degrees of involvement from statutory children's services since the birth of her child.

I first started working with Josie when she was detained under the Mental Health Act 1983 (as amended in 2007) (MHA), her first of two episodes of compulsory detention during the time frame described in this article. She had been given various psychiatric diagnoses, including those of adjustment disorder, psychotic depression, post-natal depression, anxiety and depression and borderline personality disorder (BPD), though BPD was generally given alongside any others. Psychiatrists whose care she was under had also variously voiced that she had either no mental illness or, rather, that it was masked or indeterminable due to extensive cannabis use, raising also the possibility of 'dual diagnosis' (the coexistence of substance misuse issues and mental health issues).

Working with Josie was particularly challenging at times, on organisational, practical and emotional levels, and in considering aspects of my social work practice with her, I engage here in a process of reflection, paying equal attention to the rational and irrational influences on my decision-making (Ruch, 2002), in part, to guard against 'professional dangerousness' (Wallis, 2010). Professional dangerousness in child protection refers to a process where professionals can 'behave in a way that either colludes with or increases the dangerous dynamics of the abusing family' (Morrison, 1990: 262) and is associated with a toxic combination of psychological battery by systems, service users and colleagues that reduces space for reflection and positive action. This is particularly relevant given the multi-organisational context of the work described here, coupled with the complexities of information sharing and collaboration across health and social care services. There are also particular challenges at the intersection of adult mental health and child protection (Darlington et al, 2004; Richardson and Asthana, 2006). Indeed, Darlington et al's research suggests that the difficulties in collaborative working correlate with the presence of contested issues. For Josie, understandings of risk (to her from others, from her to professionals and from her to her child) and psychiatric diagnoses were variously contested. So, too, were resources, which were often hard to find, with funding hard-fought for. It is, in part, these issues – the level of uncertainty and complexity in my work with Josie

– that necessitate a greater understanding of the pivotal moments at which these subjects were thrown into sharp relief.

On the borderline

Josie had, like many women diagnosed with BPD, an extensive history of childhood sexual abuse and has also experienced other subsequent major traumas. BPD, or Emotionally Unstable Personality Disorder (EUPD), is a highly contentious, problematic and discriminatory diagnosis that should be openly challenged by social workers as part of critical and radical practice (Proctor and Shaw, 2005). Feminist critiques highlight the gendered aspects of the diagnosis, whose recipients are around 80% female, and view the giving of such diagnoses as reducing the focus on the cultural, political and socio-economic conditions that enable male violence against women (Watts, 2016). This is relevant given the clear links between such violence, often in the forms of domestic abuse or sexual abuse, and a BPD diagnosis.

Such analyses also critique gendered power relations dependent upon social constructions of masculinity and femininity uncritically linked to biological sex. As such, female violence is always more transgressive than male violence, with the latter socially sanctioned through, for example, dominant narratives of ‘boys being boys’ (Smart, 1995). The two women a week killed at the hands of a male partner or ex-partner, whose deaths often do not even make news headlines, may be seen as the logical conclusion of such a pattern of gender inequality. Female victims of violence are also rarely granted justice through legal channels, for example, with UK rape conviction rates remaining stubbornly low, and women are often simply not believed when abuse is reported (Office for National Statistics, 2018). In such a vein, Wirth-Cauchon (2001: 211) argues that the diagnosis of BPD is the medicalisation of women’s self-destructive feelings and behaviours ‘that lie at the extreme end of a range of responses to gender contradictions and violence in late modern society’. The user-led group Recovery in the Bin, and affiliated group PD in the Bin, wrote a list of ways to avoid getting a diagnosis of BPD/EUPD, and although tongue in cheek, it is frighteningly accurate, beginning as it does with ‘try not to be female’ (Personality Disorder in the Bin, 2017). In such a context, BPD is simply the latest diagnosis in a long line of mental health interventions functioning as a tool of social control to police women’s bodies.

In practice terms, there is also an implicit (and sometimes explicit) assumption that as BPD is ‘behavioural’, people with such a diagnosis require responses from mental health services that, for example, seek not to ‘indulge’ the behaviours of self-harming or ‘attention-seeking’. There is thus a dominant narrative that people like Josie need to ‘take responsibility’ for their situation and that mental health services can help with this by responding to them in a very boundaried manner. In effect, however, mental health services often play a role in re-traumatising people by replicating power dynamics in childhood abuse, through the acts of silencing and not believing. It also often means, in effect, that services are often denied to people, serving only to reinforce someone’s sense of powerlessness and frustration and, at times, increasing risk.

Legislation and policy

The legislative context to this piece of work was broad given the complexity of Josie's needs, and it encompassed adult, children's, carer's and mental health services. Its policy context was even broader in scope as it ranged from the 10-year Teenage Pregnancy Strategy (ended in 2010) to Multi Agency Public Protection Agreements (MAPPAs), where Josie was considered as a perpetrator following threats to children's services staff, and Multi Agency Risk Assessment Conferences (MARACs), where she was considered as a high-risk victim of domestic abuse. Given the multifaceted and cumulative nature of Josie's needs, the context was underpinned most significantly by historical policy understandings of a lack of social and cultural capital: 'social exclusion happens when people or places suffer from a series of problems such as unemployment, discrimination, poor skills, low incomes, poor housing, high crime, ill health and family breakdown' (Social Exclusion Unit, 2004a).

This understanding of social exclusion was demonstrated most acutely by considerations of risk with Josie. During the time frame described, she was referred to services as both a perpetrator and a victim of violence and abuse, highlighting both her extreme vulnerability and 'lack of fit' within services, which have specific referral criteria and narrow outcomes related to these. Importantly, Josie's situation resisted a simple perpetrator–victim dichotomy. It also highlighted the power inherent in who is defined as a victim and in what context as when Alice became subject to child protection procedures, there was no longer any interest on the part of children's services in supporting the whole family unit. Much of this work, especially supporting her and her sister to manage their increasingly strained relationship, fell to me by default. Importantly, too, Josie largely saw herself as a victim but was largely seen by others as a perpetrator; she was aware of this and of the specific type of power that this gave her when dealing with professionals. I was also aware of this and used the HCR–20, a specialist risk assessment tool for violence, in a meeting with the police and a manager within children's services in an attempt to gain a shared understanding of the actual (minimal) risk of any violence posed by Josie to others.

More directly for my practice, the policy context included consideration of the recovery model in mental health, the then-government's mental health strategy (DH, 2011), and contemporary changes to mental health services. It involved navigating the relationship between these often managerialist changes and a more social framework of understanding mental distress. User/survivor-led group Recovery In the Bin articulate brilliantly how current structures of mental health care, in a context of austerity, make genuine recovery almost impossible, and that to act otherwise in a discourse littered with talk of 'service user choices' is, at best, disingenuous and, at worst, actively harmful; they advocate the socially oriented unrecovery star as a useful practice tool to counter the individualism of the recovery star and highlight its deficiencies. My practice also involved adherence to the CPA framework and consideration of whether and how Josie as a service user could possibly be placed at the centre of her care when she was often reluctant to engage with it and when her understanding of her difficulties differed so significantly to that of other professionals. The National Institute for Health and Care Excellence (NICE) rightly assert that what is important when working with people with a diagnosis of BPD is 'developing an optimistic and trusting relationship' and the need to 'explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and

attainable and build a trusting relationship, work in an open, engaging and non-judgemental manner and be consistent and reliable' (NICE, 2009: 380). Ideally, however, such rhetoric should function across all services and contexts and with all people, and I argue that the fact of Josie's BPD diagnosis actually closed down the possibilities for these sorts of relationships, within both mental health services and children's services. Most worryingly, the latter uncritically accepting the reality of such a diagnosis had major consequences for conclusions made about Josie's ability both to parent and to 'recover'.

Underpinning my practice was also an awareness of key documents that consider gender-specific mental health services and service provision for those with complex needs, such *Women's mental health: Into the mainstream* (DH, 2002), *Personality disorder: No longer a diagnosis of exclusion* (DH, 2003b) and *Breaking the cycle of rejection: The personality disorder capabilities framework* (DH, 2003a). These documents and others have long advocated for better provision for women's mental health services, and in recent years, there has been an increasing turn towards 'trauma-informed services' and specialist BPD services that work from a trauma model. The relevance of a working knowledge of these documents was most helpful, however, not in guiding my interventions with Josie, but in advocating for specialist resources for her and her family. In other words, my relationship to policy in this piece of work was not simply about 'understanding what works'. Rather, it was about enabling me to work systemically in considering the convergence of policy contexts and seeking to put policy into practice to negotiate for resources where I, Josie or her family identified a need. Thus, I could go to funding panels, as I did on several occasions, to make requests for alternative services. In drawing on a broader context and acknowledging the increasingly squeezed economic context, I worked within the existing, mainstream systems to achieve more radical aims wherever possible.

Personal relationships

The more immediate context of my practice was my relationship with Josie, which was established and maintained over the course of 18 months, often in difficult circumstances. In considering the knowledge base of this work with her, I have been particularly struck by its social and political aspects. A feminist frame and Josie's legitimate anger (and mine, expressed differently) at widespread injustice has been integral to my understanding of her situation and, in turn, the way I sought to apply knowledge. Given this, it is also useful to consider the ways in which such knowledge is used in social work, particularly given that critical and radical social work is as much concerned with addressing the structural aspects of discrimination and equality and promoting social justice as it is in working with individuals, yet, conversely, statutory social work is largely concerned with individuals. Radical social work theory often highlights the conflict between this and the realities of statutory social work:

one strand of social work rhetoric speaks of the need for user empowerment, self advocacy and anti-oppressive practice while at the same time social work has become increasingly driven by the exigencies of economic cuts, scarcity of resources, legislative and administrative reform, leading to a more procedural practice aimed at tighter social regulation. (Forbes and Sashidharan, 1997: 490)

So, I am considering not just the ways in which Josie variously held and did not hold (or sought to gain) power, for example, in her threats to children's services workers and her relative powerlessness to challenge the ongoing child protection procedures, but also the ways in which I did and did not hold power when working with her.

Trevithick (2008) and Osmond (2007) both explore ways in which practitioners use this breadth of knowledge in practice, both conceptually and instrumentally, and the ways in which the interactions between these can open up creative and critical possibilities, particularly for challenging inequalities. As Osmond states: 'the ends to which knowledge is put can be quite diverse ... the shape and ends of practice can then, if desired, be subtly or dramatically redirected' (Osmond, 2007: 235–6). Trevithick identifies the primary knowledge categories of theoretical, factual and practice/practical/personal or empirical knowledge, and Osmond considers the ways in which these function in practice, identifying awareness, prediction, alerting, comparison, generalisation, direction of practice behaviour, promoting an attitude and/or ethical stance, education, rapport development, and problem solving. In considering the various ways in which I have worked with Josie, my knowledge of feminist politics and feminist social work is inseparable from almost all of these aspects that Osmond identifies.

For example, it framed the lens through which I viewed (with her), her history of sexual abuse and a critical consideration of how her difficulties were conceptualised within mental health services. As such, I placed her difficulties within a broader context of an epidemic of male violence against women and deficits in the criminal justice system with regards to sexual abuse and domestic violence. It framed my commitment to working with her despite the complexities of her engagement and an organisational scepticism from my managers about the ongoing work since Josie would often 'not engage'. It also informed my approach to linking her in with women-specific and family therapy services informed by a feminist analysis of trauma and whole-system support, and to advocating for these services on an organisational level. Coupled with attachment theory and models of child development, it also enabled me to understand her own difficult relationships with others and to consider the implications for her and her sister, as well as for her daughter, of the horrifying spectre of child protection proceedings. Perhaps most importantly, feminist social work informed my therapeutic optimism and hope for the possibilities of change, as well as my attempted application of empathetic, social-constructionist, narrative and solution-focused approaches, philosophically rooted in a framework of worker as facilitator rather than knowledge-provider.

Orme (2013: 96), in particular, identifies the relationship between feminist social work and empathy, based on understandings of multiple truths for every individual, and she talks of 'being prepared to hear the conflicts and confusions ... the recognition that "your claims are valid for you but mine are valid for me"'. This framework enabled me to safeguard against my own judgements and try to remain focused on her realities, without obscuring the very real structural inequalities at play in Josie's life. Orme (2013: 96) also explicitly identifies this link between the uniqueness of individuals and social and cultural contexts that help to define our realities 'by suggesting that the personal, individual and private experiences of women are a legitimate focus for, and site of, political action'. This chimes with the classic feminist mantra of 'the personal is political' and the social work understanding of the person in their environment, underpinned by the International Federation of Social

Workers' (IFSW, 2014) definition of social work: 'social work's legitimacy and mandate lie in its intervention at the points where people interact with their environment'. Individual realities, experiences and the difference in meanings ascribed to events are thus still acknowledged, alongside an analysis that views Josie's life through a gendered, racialised, social-class-aware lens. Indeed, when working with Josie, I consistently tried to advocate for her involvement in women's groups, such as the Freedom Programme for domestic abuse, partly so that she could be supported by women in similar situations and partly so that her experiences could be put into a social and political context in a way that individual interventions simply cannot do.

Professional relationships

This reflection also focuses on some of the challenges to the application of this knowledge and, indeed, to the implementation of the recovery model in practice, including its critique. For some time now, the CPA framework has established the centrality of the principle of good communication between all those involved in a person's care and their involvement at the heart of care planning (DH, 1990, 2008b). In keeping with this, shortly before Josie's admission to hospital under section, when she had begun to retreat into a depressive state and she and her sister were struggling to manage this and yet were rejecting possible help from the Crisis Resolution and Home Treatment Team (CRHT), I sought and acquired emergency funding for her to go to a mental health nursing home for a period of respite.

This plan was arrived at in collaboration with the CRHT, children's services, the carer's support worker and Josie and her sister. At this point, the CRHT were refusing to work with Josie until her cannabis use reduced (highlighting service complexities associated with 'dual diagnosis'), Laura was stating that she needed a rest, children's services wanted Josie away from Alice and although Josie was able to articulate little at this point, she agreed to the option of going elsewhere for a few days. I drew on my knowledge of her previous hospital admission and its relative lack of positive outcomes, as well as the course of events prior to that admission. While sceptical about its underlying validity and blanket application, I was also aware of best-practice guidance on avoiding compulsory admissions where possible, unless well planned for and goal oriented, for those meeting the criteria for BPD (NICE, 2009). I was, however, anxious about arranging this as I was aware that it may not work and was also aware of perceiving a pressure to act by children's services – to 'do something', rather than 'do nothing'. On reflection, it would have been beneficial to have made more opportunities for shared reflective practice with children's service's staff to guard against 'defensive decision-making' and explore service limitations jointly and more slowly (something that we became much more adept at doing as time progressed). Only days into her admission, when staff at the respite placement did not feel able to manage Josie's increasing distress, a Mental Health Act assessment was called and Josie was compulsorily detained in hospital.

During the hospital admission, Josie refused to engage with staff and damaged property on the ward. Alice's social worker, Kim, and I arranged to meet with her on the ward to consider how to proceed with the CIN plan, but when we arrived, the meeting was termed a discharge CPA, called by the consultant psychiatrist, at which Josie was discharged from her section. I am acutely aware of how angry and powerless both Kim and I felt at this time and how this context of poor communication

and management within mental health services enabled a situation that should not have taken place to do so. I am also aware of my inability to employ emotional intelligence to have managed the situation differently in that moment given the established relationship between mood and emotion management in decision-making (Morrison, 2007). I used the complaints procedure and my relationships with colleagues across services to gain support, continue planning for Josie and mitigate against my frustrations affecting my relationship with Josie or impacting on her use of services. As Morrison (2007: 253–254) states:

[that] vulnerable users have suffered multiple experiences of disregulated emotions, inconsistent care and unpredictable danger, in response to which they have developed emotional antennae which are highly attuned to the emotional demeanour of those on whom they may depend, must not be forgotten.

Tew's (2006) model of 'power over' and 'power together' was useful in considering protective power, oppressive power, collusive power and the aim of cooperative power. This was largely in relation to how I continued to best work with both children's services, particularly my colleague Kim, and the psychiatric hospital ward after the move to Alice being made subject to child protection procedures. This process was initiated following the hospital discharge CPA, where the lack of effective planning resulted in Kim feeling forced to seek an Emergency Protection Order for Alice, which also resulted in Josie being made homeless, an arguably much greater crisis situation than was the case prior to the hospital admission.

We endeavoured to hold regular professionals' meetings since that time so that we were equally aware of each other's care planning, could adapt those plans and could maintain clear, consistent and safe relationship boundaries with Josie (for all of us). It was noticeable that when these were missed (due to time and resource constraints), it impacted on our working relationships since, as Tew (2006: 46) states, relationships of cooperative power 'must recognise the real imbalances of power, authority and access to resources that may exist between the different parties – and there must be explicit permission for such issues to be talked about openly'. I was able to use these continued attempts to model cooperative power with children's services to jointly plan for the conclusion of child protection proceedings, using our shared knowledge to assess and manage risks associated with this, particularly for Josie and her sister. We also sought to understand together the inherent difficulties associated with my continued work with Josie and how her mental health needs were now predominantly focused on the child protection process. The emotional impact of this process is both unimaginably awful and notoriously poorly responded to and resourced in terms of services for parents whose children have been made subject to these processes, with women largely reporting feeling blamed, powerless and that their strengths are unacknowledged (Ryburn, 1992; Mason and Selman, 1997; Morriss, 2018).

Using my therapeutic relationship with Josie, I was able to respond to her request to be 'kept safe' when proceedings concluded. I understood this in the context of attachment theory, the framework within which I considered her violent behaviours when in a secure environment, where she was able to seek 'containment' and demonstrate her distress in a manner that was ordinarily impossible. From a critical and feminist perspective, too, however, the social and cultural connotations of disrupted

motherhood are also far greater than disrupted fatherhood. The impact of this is significant, particularly in considering Josie's anger, shame and retreat from services or 'non-engagement', both at the time and at potential future points (Morris, 2018). I used a consistently collaborative approach with her, attempting to again model cooperative power and enabling me to be honest with her about my view of her needs by showing her my child protection court reports. I had greater organisational flexibility than children's services staff in the writing of these reports, but nonetheless had a perceived authority that she did not, and I tried to use this responsibly. In doing this, I drew on a knowledge base that consistently asserts the importance of the working relationship or alliance over other therapeutic factors (McKeown, 2000). This led to me to advocating for funding for a women's therapeutic community for Josie and I used my relationship with children's services to draw on their support for continued funding applications for services for her.

Conclusion: feminist social work – child protection and mental health

Josie, Laura and Alice are an anonymised illustration of a real family but there are thousands of similar families all across the UK. Working with them takes time, space and organisational support, which are often sadly outweighed by process and procedure. It also arguably requires different models of working to those that we currently have, models that would embed both feminist social work practices and a more holistic and nuanced way of understanding the needs of everyone in the family where there are concerns about a child. This would go beyond the good 'joint working' that I hope Kim and I achieved during the work described, to something more akin to a shared process. It would also be more unapologetic in its use of social work knowledge and less deferent or uncritical of psychiatric knowledge and the consequent social power that this wields. At a time when contemporary social work research highlights an urgent need to reconfigure understandings of what family is, it is urgent that we reconsider social work responses to it (Featherstone et al, 2014; Morris et al, 2017).

Perhaps most important to this project for those concerned with the desire to re-establish critical and radical social work within statutory services is an engagement with the political context, which has changed between the time of undertaking this work with Josie and writing this article. Josie and her family had a lifetime's worth of experience of living within and navigating social exclusion and its consequences. Their individual, though explicitly gendered, experiences of various forms of abuse operated within this context, as did their complex and often reluctant relationships with state services. Understandings of this are, however, increasingly being subsumed beneath narratives of individual responsibility, of which the mental health recovery agenda is arguably a cornerstone that must be challenged. Discussing research with social workers around understandings of the family and child protection procedures, Morris et al argue that with the demise of the social exclusion agenda and associated discourse, new relationships between the state and families are being forged. In this new terrain, struggling families are being repositioned as 'wilfully failing to take up opportunities to become hard working families, or are argued to be making "poor choices" e.g. to live in violent relationships' (Morris et al, 2017: 52). As individual

agency is privileged over social and economic circumstance, the latter is lost sight of (Gupta et al, 2014; Gupta, 2017; Morris et al, 2017).

I argue that there are clear parallels between child protection social work and mental health social work, characterised by this shift in balance away from more social and political understandings of the contexts in which people's lives play out, to individual explanations of behaviour. As my work with Josie shows, these are particularly relevant when women have diagnoses of BPD, with its associations of both difficult current behaviour, characterised by 'manipulation' or 'attention-seeking' in relationships with staff, and a past history of violence or abuse. Social work can and should be an ultimately optimistic, hopeful exercise, but it can only be so when the broadest of connections are made. In doing so, the structures that impinge on the power relationships that we have with those we work with can be exposed and altered for the better, and the aims of critical and radical social work can begin to be realised.

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Conflict of interest

The author declares that there is no conflict of interest.

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