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Abstract
Social workers in health care often argue that they must be professionally assertive in order to keep their values afloat in a stormy sea of change. The practice of health social work has traditionally been tied to a professional identity derived from a claim to expertise in the 'psychosocial' aspects of health and illness. This article briefly reviews relevant literature on health social work in institutional settings, with specific reference to the links between knowledge, credentials and a secure professional identity. Data from a small study is used to examine the problematic nature of professional identity and links between continuing professional education and status in health social work in New Zealand. Findings reveal practitioner concern that the knowledge claim of social work is weak and this impacts on their professional identity and status in multidisciplinary institutional settings.

Keywords
Health social work, knowledge claim, professional identity

From a 'go-between craft' to an established profession

In 1919 Cabot published a series of essays on the relationship between an emerging social work occupation and the medical profession. His conception of social work was of a social practice under the patronage of doctors. In the same year Todd (a sociologist) urged social workers to be scientific in their approach to practice: 'the scientific spirit is necessary to social work whether it is a *real profession* or only a *go-between craft*' (Todd, 1919: 66 italics added). Cabot's approach is distinctly medical, while Todd's sociological perspective provides greater breadth and potential for the profession to be more distinctive. Both perceive social work as intrinsically caught up with the alleviation of suffering at the individual, family and

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community level, while recognizing that social change is needed to reduce disparities. Where they differ significantly is in their understanding of social work's striving for a distinctive space and a knowledge-base to support more than a '*go-between craft*'. As demonstrated in this present article some issues remain constant!

Auslander (2001: 201) in her review of social work in health care, reminds us that social work in health settings has been in existence for more than one hundred years. Auslander (2001: 205) asked the question: '*Social work in health care: what have we achieved*?' and using the Delphi Technique, 36 experts identified the greatest accomplishments in social work in health care, with the final set of 20 described in detail in Auslander (2001: 210–215). Of significance to this current article, among the 'Top 20' were: 'the incorporation of bio-psychosocial and holistic approaches into mainstream health care'; 'recognition of social work as a legitimate discipline', and 'increased professional autonomy'. Auslander's research found that the highest ranking item was considered by the expert panel to be 'the influence of social work upon mainstream health care to adopt a broader conception of health and illness' (Auslander, 2001: 210).

Auslander (2001) refers to a shift away from the 'disease' paradigm (biomedical), a rational, scientific (read positivist) model in which the focus is on observed clinical data followed by the application of physical treatment. She suggests that social work has contributed to a social model of health (psychosocial) which takes into consideration social, psychological, spiritual, cultural and ecological factors (Auslander, 2001: 211). The bio-psychosocial model views disease as interplay between environment, physical, behavioural, psychological, and social factors. Social work traverses the impact of social, cultural, and economic conditions on health; the impact of illness on personal and family coping; the need for social support; and the importance of multi-professional collaboration on individual and community health problems (Bracht, 1978). In the United Kingdom, Bywaters (1986: 670–674) proposed a social model of health social work that incorporated the following elements: health as a human right; responsibility for health as citizens and consumers rather than an expert-dominated system; the acceptance of social and environmental factors as crucial to health; a role for social work to assert 'the value of care as well as cure'; social work support as a right, unrestricted by gatekeepers; provision for self-help groups and assistance for consumers to find and disseminate alternative sources of information.

The history of health social work, therefore, is of a complex struggle to define itself within the context of a health system with many other powerful players. Bywaters (1986: 663) acknowledges the long association of social work with the medical profession and the 'other' history, 'viable but less articulated, a history of interprofessional conflict, of the widespread emasculation of social work in hospitals'.

Bourdieu's (1984) concept of a 'distinctive space' proves useful in exploring the professional capital of social work in health care (Beddoe, 2010). Professional capital is defined here as the aggregated value of mandated educational qualifications, social 'distinction' based in a territory of social practice, and economic worth

marked by the artefacts of professional status, occupational closure and protection of title (Beddoe, 2010: 246). This is aligned to the Bourdieusian (1986: 246) construct of social capital 'the aggregate of the actual or potential resources' linked to 'durable networks' of relationships which 'may exist only in the practical state, in material and/or symbolic exchanges which help to maintain them'. Bourdieu (1984: 251) writes of symbolic power:

> The struggle to win everything which, in the social world, is of the order of belief, credit and discredit, perception and appreciation, knowledge and recognition-name, renown, prestige, honour, glory, authority . . . always concerns the 'distinguished' possessors and the 'pretentious' challengers.

Knowledge and more specifically credentials are thus crucial in determining professional status. This article briefly reviews relevant literature on professional identity, with specific reference to the role of knowledge. Data from a small study of continuing professional education (CPE) is drawn upon to examine the problematic nature of professional identity and status in health social work in New Zealand. In the New Zealand context, health social work refers to the practice in multi-disciplinary institutions covering physical and mental health. In New Zealand, social work practice in primary and public health is in its infancy.

Professional identity: The 'distinctive space'

A profession's capital is symbolic and material and is demonstrated in myriad exchanges within societies and fields (Beddoe, 2010). The key attributes of professional capital of any given profession within its social milieu include: being trusted by users of professional services, key stakeholders and other professions; having congruent values within the profession; having mutually rewarding relationships with other professional groups; being able to perform roles of leadership in a field; having reciprocal relationships, with some form of exchange; holding a sense of collective identity and 'self-esteem'; a clear and understood knowledge-claim for practice, including the production of knowledge; a clear and well differentiated territory of practice; opportunities are available for CPE, and finally, visibility in the public discourse for its distinctive contribution to social well-being (Beddoe, 2010: 105–106).

While the premises for social work in health care (Bracht, 1978; Bywaters, 1986), described in the previous section, provide an excellent blueprint, the relative lack of independence in health settings suggests that social work has been a 'guest' under the benign control of the medical and nursing professions. The development of professional identity within contestable territory is highly complex. 'Social Identity Theory' is relevant here as it outlines that the attitudes and behaviours of members of one group in respect of another are influenced by the strength of members' social identity (Turner, 1999) and 'professional identity, as one form of social identity, concerns group interactions in the workplace and relates to how people compare and differentiate themselves from other professional groups' (Adams, Hean, Sturgis

and Clark, 2006: 56). Professional identity develops over time and involves the attitudes, values, knowledge, beliefs and skills that are shared with others within that profession. Turner (1999: 8) cites Crocker and Luhtanen (1990) as positing 'collective self-esteem' to depict the process whereby people evaluate themselves 'in terms of in-group membership' requiring favourable comparison with 'relevant outgroups'. In the study of the professions the traditional traits approaches (Greenwood, 1957) have largely been rejected in favour of perspectives that examine the processes of professionalization (Witz, 1992). Such perspectives recognize the importance of self-categorization and delineation of territory. Professional practitioners work with diverse and different 'others' within bureaucratic, legal and organizational constraints. Roach Anleu describes this as a 'role set' of 'audiences for jurisdictional claims' (1992: 25), where groups possess varying interests and values and noted that the dependence of social workers on the legitimization of their work by members of the powerful groups provided sources of conflict and tension.

Thus, health institutions have not always been a comfortable place for social work and Bywaters (1986: 670), emphasizing a power relations approach, wrote that the profession is 'at odds with medicine in its central belief in a respect for the client's self knowledge and right to choice, and in its growing recognition of the value of mutual support and exchange'. The social work stance that it makes a significantly distinctive contribution to patient well-being is central to self-categorization and recognition.

In this study, a process approach is employed in the discussion of how professions develop, for many definitional issues still preoccupy sociologists of occupations. There is a general agreement that power, mandate, trust, expertise and some form of public exchange of value (professional capital) are crucial elements in the discourse of professions (Evetts, 2006; Olgiati, 2006) as it develops over time, although each of these alone provides an insufficient explanation of professional status. Roach Anleu explores the nature of *mandate* in her qualitative case study of three groups of social workers: child welfare workers, probation officers and hospital social workers in Australia. Roach Anleu notes that the formal mandate held by child welfare and probation workers enable them to counter encroachment by appeal to legal rights and responsibilities (1992: 41) and such autonomy is crucial to professional status. This decreased the need for credentials (codified knowledge claims) in child welfare and probation. Child welfare workers and probation officers were 'better able to counter attempted encroachment by appeal to legal rights and responsibilities, regardless of comparative expertise and skill' (Roach Anleu, 1992: 41). Roach Anleu noted that while occupational autonomy was stronger in the mandated groups of workers, professional self-identity was stronger in health (1992: 41). Hospital social workers supported their claims to make a 'distinctive contribution to health and illness', by alluding to the content of their qualifications and their perception that doctors and nurses limited their focus on physical factors and treatment (Roach Anleu, 1992: 40–41).

Credentials are significant to establishing identities in society where dominant interests might seek to define 'legitimizing claims' (Castells, 1997: 8). Credentials

are thus particularly important to health social workers, as they signify the validity of their knowledge claim in the absence of formal statutory mandates (Beddoe, 2010). As will be shown in this article many social workers feel they have an insecure knowledge claim. Credentials may signify knowledge which signifies distinction in multidisciplinary environments. Those in this present study will be shown to feel vulnerable in that they must constantly justify their particular contribution. The regular assertion of a claim does not necessarily ensure its validation in practice, but the enactment can. Payne (2006: 139–140) argues that social work has persisted as a practice, over more than a century and may thus be seen as 'fairly stable, emerging in patterns of relationships with other occupational groups, reducing the social need to establish and defend its institutional position'. For Payne (2006) social work identity is constructed through negotiation of roles alongside practitioners and service users, where effective relationships contribute to a developing enactment of what social work does, rather than any prescribed or mandated definition. In the current climate mandates are powerful and the larger study (Beddoe, 2010) found that social workers held hopes that registration would bring greater status and security to the profession and raise scholarly engagement in research (Beddoe, 2011).

Partnership or 'unconditional collaboration' – the problem of medical dominance

From a process perspective (Witz, 1992) professional identity may thus be seen as developing over time through negotiating roles and relationships with others. Roach Anleu (1992: 24–25) has suggested that, rather than conceptualizing strong professionalism in bureaucracies as 'intrinsically and by definition incompatible', it is more helpful to examine how they work together within different organizational contexts. Her study found that hospital social workers had the least successful claims over work with particular patients and activities, despite having the 'most sophisticated professional ideology' and being required to have recognized qualifications (Roach Anleu, 1992: 26–27) as a consequence of limited decision making authority and 'the dominance of the medical profession'.

Bywaters (1986) acknowledges the long association and collaboration with the medical profession. He notes that Cabot wrote in 1919 that the social worker was part of the medical organization and should not pursue independent research (Cabot, 1919). Thus, while collaboration was ostensibly valued, 'control' remained with the doctor. Of great interest here is Bywaters' (1986: 663) identification of another history, 'viable but less articulated, a history of interprofessional conflict, of the widespread emasculation of social work in hospitals'. Bywaters (1986) traces these struggles of social work through recorded examples of social workers having to work outside the system in order to survive hostility and non-cooperation from nursing and medical staff. His review of this literature over seven decades of social work in health demonstrates a range of complaints that are probably not unfamiliar to health social workers in general settings today: the lack of referrals from

some surgeons and physicians, narrow or late referrals, non-recognition of social, cultural or spiritual needs of patients, being expected to be bed-emptiers, and opposition from nurses.

In the 21st century however, there is some challenge to the strength of medical dominance (Willis, 1983) that characterized these earlier accounts. Changes in the nature of knowledge, the influence of mass media and the vast access to knowledge offered by the internet have altered some aspects of the previously held as 'unbreakable tie between knowledge/expertise and power' (Coburn, 2006: 438). In addition, professions have been found wanting in the past four decades (Evetts, 2006; O'Neill, 2002), and the claim of specialist knowledge is no longer sufficient to guarantee trust and autonomy, suggests Coburn. It can be argued that evidence-based practice (EBP) challenges the potency of an exclusive knowledge claim for any profession as EBP aims to evaluate practices against other practices, using so called gold standard methods (Coburn, 2006) to produce 'Best Practice'. Within new models of public management, technologies of control such as 'clinical governance', bureaucratic agents assert control of professions. Medical dominance (Willis, 1983; 2006) is thus weakened. In spite of these changes, for social work, dominance gained by the capture of specialist knowledge has never been achieved and its programmes have always been mediated via third parties. The weak knowledge claim of social work is in a circular relationship with considerable organizational limitation to professional autonomy.

In the study reported in this article, anxiety about professional weakness is demonstrated in the numerous references to other disciplines and in particular the medical profession. For social workers in multidisciplinary settings there is considerable support for strengthening their knowledge claim in order to have a place at the table.

The study

The qualitative data discussed in this article are drawn from a larger study of the role of continuing professional education (CPE) in New Zealand social workers' understandings of the nature of the profession (Beddoe, 2010). The main study explored practitioners' agency in their CPE choices and the impact of organizational factors. The data gained were reviewed against the profession's stated social justice mission. This study was undertaken during a period of intense change in New Zealand social work, brought about by the requirements of new legislation to register social workers. The study employed both semi-structured individual (17) and (6) group interviews involving 40 social workers, professional leaders and managers. The participants in this study were 80% female ($N = 33$) and in age, 60% were aged between 30 and 50 years. European participants were the majority with 80% ($N = 32$); followed by Maori (10% $N = 4$); Pasifika (7% $N = 3$) and 2.5% ($N = 1$) Chinese. The participants held a range of qualifications, from undergraduate diplomas and degrees to doctorates. Two group interviews were context specific (statutory child protection and mental health). These are large fields of

practice in New Zealand and have different organizational cultures. Setting up groups ensured that institutional differences could be identified. Four groups were mixed. Sixteen participants worked in health and mental health institutional settings and all were volunteers in this study recruited by advertisement. The study was approved by a university ethics committee.

Gadamer's (1989) contention that the social frames of reference influence the researcher's approach to selection of subjects and subsequent interpretation of data is an important consideration here. As a researcher the author of this article held disciplinary orientations (social work, sociology) membership of social groups (academia, professional bodies) and a theoretical orientation (critical theory). The author held multiple roles in the profession during the data collection period. The approach to this study was therefore not without the affiliations which Gadamer (1989 cited in Kincheloe and McLaren, 2000: 288) views as 'horizons' and considers the act of interpretation as thus 'the fusion of horizons'. My roles led to my interest in the study questions and enabled me to test ideas and findings as I worked with practitioners in many informal and formal settings: meetings, conference discussion and so forth. The interview schedules of both the individual and group interviews had many items in common and were derived from the research questions. Data were analysed using qualitative methods to locate patterns within the transcripts. The transcribed data were coded line-by-line and the text examined closely with the assistance of qualitative research software, which enabled repeated text searches. Drisko (1997: 193) asserts that 'researchers should compare qualitatively derived local theories to the interpretations and meanings framed by formal theories on similar content'. The rich literature of the sociological study of the professions remained fruitful throughout the analytical phase as did the examination of two Australian studies of a similar focus (McMichael, 2000; Roach Anleu, 1992).

During the data analysis stage, questions asked of the data included: are there common stories? Is there a common language of description? Are there dominant or competing stories and are these shaped by dominant discourses? Comparisons with other professions and other fields were made by the interviewees and were coded when analyzing the data, and these immediately significant themes were identified (for example: *comparative status, professional identity, registration* and *credentialing*). Analysis included frequent re-examination of the literature, in order to explore whether phenomena emerging could be explained with reference to the findings of other researchers and avoid the risk of the researcher's voice dominating interpretation of the data. Hansen describes this iterative process with data and literature (1995: 70) as a 'double helix operation: one spiral representing the ongoing data analysis in the form of anticipatory data reduction and the other spiral representing ongoing data gathering in the form of increasingly specific research foci'.

The major themes which emerged from the larger study included strong links between CPE and the professionalization agenda of social work; the impact of the organizational context on practitioners' sense of esteem; the complex links between

CPE and forms of social and cultural capital, and lastly a greater understanding of the barriers to social worker engagement in further education and research (Beddoe, 2011).

The findings

This article reports specifically on health social workers' linking of knowledge, academic credentials and professional identity. The sub-themes examined in this article include issues of status: 'measuring up', the knowledge claim and status and social work advocacy in health settings. The strength of the relationships between education and scholarship, comparative status and identity was not anticipated, but emerged in the data analysis process.

Measuring up

The comparative status of social work in relation to other professions emerged as a significant theme. In the first interview, a hospital based participant commented on the '*day to day awareness of having to pit yourself against other really bright and intelligent people*' (Summer, child health). There was a sense that participants were assessing themselves against the perceived 'smartness' of other health professionals. Participants frequently made reference to the belief that in relation to resources for CPE, research and scholarship, social work is not well supported: '*[social work] is never going to foot it with doctors and nurses somehow because it's a much more nebulous sort of undertaking I guess*' (Dave). The expertise claim of social work feels inadequate in the multidisciplinary world and there is a strong consciousness of a hierarchy of professions in which social work is lowly rated (Beddoe, 2010). In a research note I noted that group interview participants used battle metaphors to describe their venturing into the medical world and tended to link CPE to this struggle. There was a sense that social workers needed credentials to persuade others that social work had something to offer, as this interchange indicates:

> Don't you agree that part of the need for us for ongoing training is knowledge to compete against other health professionals . . . you have to fight on the battlefield otherwise you lose. (Alan)

> Yes, that is one reason why I am doing my Masters – it didn't seem to matter that I had an opinion – I wasn't on the same battlefield and if I got to the Masters level suddenly they start listening . . . if you want to be taken seriously . . . you do have to recognize the game and you have to get into it with your ticket. (Tonia)

For Tonia then, a higher degree was an ideological weapon aimed directly at a status 'game'. A return to the data to search for the words 'fight', 'battle', and 'struggle' found that the use of these words was quite common across all of the

interviews (Beddoe, 2010). Thus postgraduate study was seen as essential to gain respect in the multidisciplinary team.

Research by Taylor, Beckett and McKeigue (2008: 25) identifies social workers as the 'prime candidates for the projection of society's anxiety in the form of criticism' and yet characterized as having less expertise than other professionals. This is inevitably tied to the role of health and welfare in the risk society (Alaszewski and Coxon, 2009). In Olgiati's (2006) argument on the influence of risk on public trust of the professions, managing risk is inextricably tied to competency. In a setting where a profession's attention is focused on risk, technical 'safety' becomes a preoccupation. Social workers deal with risk *and* suffer the lack of a well-understood public role in a '*nebulous undertaking*' thus lacking Bourdieu's distinctive space, vital in securing position in social fields.

More than two decades later a social worker in Taylor et al.'s (2008: 25) research said 'I think the courts will look on the doctor, or the psychiatrist or the psychologist's report as having more weight . . . than the social worker's report. Because doctors are really professional aren't they, it's one of those careers your parents want you to go into whereas social workers . . . !' McMichael (2000: 177) commented that social work was seen as 'valued in pockets', not always valued for what it would like to be valued for and that 'social work has an identity crisis with its self-perception'. Social workers in this study were sensitive to symbolic capital, being 'named' and having their contribution recognized thus signalling inclusion. Frances illustrated this and I noted that despite being '*always included as integral to the team*' she took issue with her profession not being named in paperwork:

> Frances: . . . I think that social work in health is still kind of like the 'add-on'. I mean one of the things that I have wanted to do in my role . . . is to have social work [listed in] the referral form. Social work is here – we are always included as integral to the team and yet it says' nurses, doctors, therapists' and 'other'. . .
>
> Liz: It is one of those little symbolic things?
>
> Frances: Yes it is actually. I want the form changed. We are not 'other'.

There were several mentions of doctors being 'scientists' and a related theme emerged that social workers must speak the language of research in order to have a place at the table. This anxiety about the strength of the knowledge claim is present in the numerous comparisons made between social work and the medical profession, and an example is presented in Table 1 'The Doctors', where access to resources is the focus. Clearly these comments suggest that social workers attribute some of their problems to access to resources for building their credentials and a common belief was that others had greater resources and greater influence. Many comments reflected the more common experience that social workers felt their status was reflected in unequal provision of resources.

Table 1. Comparisons with the doctors

Working in health, the main focus is on the medical people (Claire).
I would have to say generally because it is a medical model, the learning environment is just focused on medical staff (Claire).
The doctors are bound to be getting some goodies like that (Bill).
I mean your doctors are going to have resources because it's tradition (Bill).
Doctors have an expectation of being able to go to conferences (Claire).
The learning environment is just focused on medical staff rather than allied health (Claire).
I am unsure we have an overall policy but I guess the doctors would have it built into their contracts and nurses as well (Claire).
Doctors and nurses training programmes are expected to be there . . . (Collette).
There are doctors who feel that only doctors and lawyers are professionals (Collette).
You're never going to foot it with doctors and nurses somehow (Dave).
Other than the doctors we are pretty well off (Focus group).
Oh doctors are brilliantly funded (Frances).
Social work doesn't even get a look-in whereas with nurses and doctors it's considered an expectation . . . and they have a budget set aside (Jill).
It is a mandated requirement in regard to doctors so they get huge [resources] (Megan).
In health of course the doctors set the baseline (Focus group).
Just not funded to the same level as the doctors of course (Focus group).
Well it is never going to stack up with the doctors (Summer).

After the second and largest focus group, I wrote a further research note:

> It struck me today how significant status is for the social workers I am talking to. They are incredibly status conscious and seem to be constantly comparing themselves with other professions, in people working in non-health environments this is not so obvious but is still present.

Whether asked to, or not, the participants in this study raised comparisons, between themselves and other professionals with whom they worked, alongside or in interagency relationships. A sense of hierarchy, 'the pecking order' pervades this description of how social work fares in institutional health settings and others.

The knowledge claim and status

Credentialing is very significant when asserting a claim to a distinctive space: social workers have individual and collective aspirations; these may be shaped by public and professional discourse. Jarvis (1996) argues that one of the consequences of the greater demarcation of the workforce in contemporary society is the need for credentials and the concomitant professional recognition of being 'up to

date'. The higher qualification is pragmatically valued for what it symbolizes, as Jill notes:

> They want to see that you've got ten thousand letters after your name, particularly when you work in health and you sign your name next to a doctor who writes like two lines of his credentials underneath and you just write BSW. (Jill)

Even when we consider social work research, there is a question of rigour. Within one interview, the tendency to favour qualitative research was mentioned with a hint of disparagement by one participant and provided a 'sticky' moment for the researcher (Riach, 2009):

> We tend to really not have had rigour in a lot of what we call research. I'm talking about the sort of things in the international journals, The Lancet or The BMJ or stuff like that, that's got a bit of rigour behind it and I'm not criticizing what we're doing *here* but we tend to have qualitative research ...

In spite of these mainly negative comparisons, several participants spoke of the knowledge and skills of the profession in relation to intimate knowledge of clients' worlds. Collette and Tonia emphasized the broad knowledge base and scope of social work and saw this as both strength and a weakness, and certainly demanding in terms of managing ongoing professional learning. This was expressed as a challenge and strength for the profession:

> If I took one day in the life of a social worker, and I presented that hectic day in emergency care to your average registrar, physio or OT, the self disclosures of abuse, the trauma that people survive... I would guess that 90% of the other disciplines would say – 'wow that has been a hell of a year you have had', and the social worker would say, 'that was Monday'! (Collette)

The nature of the profession and its broad engagement across a spectrum of practice situations was vividly described by Tonia:

> It might be being arrogant on my part but I see social workers, more than any other profession needing to have such a vast knowledge of all sort of different things so that you can draw on ... I think you just, depending which area you go into, it [knowledge] just keeps expanding and your head feels like it will explode sometimes but that is the responsibility we have as social workers. (Tonia)

While Tonia saw this breadth of knowledge as significant, others perceived it as more of a superficial knowledge, perhaps lacking the mastery that came with depth, and as noted earlier, Tonia chose to take a research Masters in order to be on the 'same battlefield' as other health professionals. Two participants used a colloquial description to try to explain the impact of this breadth, capturing it in a common

expression. Phil commented '*social work is such a broad kind of profession that you kind of come out like a jack of all trades but master of none'*. This was echoed by Lucky:

> When I first began in social work, [an academic] said 'look social workers are regarded as a jack of all trades and master of none' and I don't know to be honest .... if things have really changed that much.

As noted earlier, social workers felt there were challenges from related professions such as nursing, psychology or 'counselling' to work in the traditional core areas of social work (Miller, 2006):

> My major concern is about psychology and counselling, we are going to get ourselves into some trouble if we don't keep our tails up actually. (Megan)

Health psychologists were seen as a potential threat to the psychosocial territory of social work in a busy tertiary hospital:

> Yeah because [psychology] is a direct challenge ... I think there is a definite feeling at the moment that somebody ought to make the psychologists go away.

Social work advocacy

A number of participants clearly advocated for social work to provide a challenge to the medical paradigm; they wanted to encourage practice that uses health social work role as an 'insider' to be advocates for social reform and policy and practice innovation. The power of 'the system' to suck social workers in was also recognized by Frances, who felt it was a lack of analysis that led to inertia. Participants described the ideals of social justice, so significant in the self-defined 'identity' of social work as being unrealized: Frances expressed this in this passage that was spoken with considerable vehemence:

You know what; we are supposed to be political! We are supposed to challenge systems we are supposed to fight injustice and what happens you get a group of social workers together and say well what do you want?

Alan's 'take' on this issue was that it required training '*to maintain advocacy year in year out*'.

Group interview participants felt that in mental health it was easy to become part of the clinical system and that might weaken their adherence to those foundational principles of social justice:

> I think you are strongly in danger of just becoming another mental health worker. I think we are encouraged to become a mental health worker here: a clinician. A case manager. The social worker that is sometimes diluted or lost.

> I think personally . . . I have lost sight of some of those other broader idealistic ways of seeing the world.

> I suppose [being at] the cutting edge of mental health treatment, [social justice] seems a long way off.

Maree felt that there was complacency amongst many colleagues: 'I'm *helping people and that's enough*'. She felt that social workers in health could do more, 'we're *only scraping the surface . . . we could be so much more out and doing*' on issues such as health funding and health inequalities. There was a great sense that people just feel bogged-down with the day to day and being in the system:

> I think that one of the common difficulties is that people are so consumed with the minutiae of their day to day work that they forget why they are here. Why the people are here? They don't look at clients in context. (Frances)

This was echoed by Jill who felt that social workers get swallowed up in the emotional demands of the work:

> I'd like to think we could do it far more effectively if we are a healthier profession because we're dealing with such a lot, we have such potential to 'do change' if we energize.

> We get so caught up in the micro we might have more time for the macro and social justice stuff if we weren't so cloistered.

Discussion

Social work operates within broader health and welfare systems able to be conceptualized as fields in the Bordieusian sense. Practitioners construct their professional identity within these complex, often hierarchical fields. For Bourdieu these sites contain complex sets of power relations in which strategies are employed by participants to gain traction in meeting their aims. Bourdieu's conceptual tools prove helpful in developing an explanation for this troubled identity, demonstrated here, as he located emerging professions such as social work and counselling in 'the interstices between the teaching profession and the medical profession' (Bourdieu, 1984: 369), with indeterminate status. Earlier a number of essential features of strong professional capital were described. Features of weak professional capital accordingly will include: invisibility in the public discourse of professionalism; the profession being associated with negative outcomes; lack of recognition for the contributions of the profession to society; lack of a clear territory of practice; a passive role in institutions rather than leadership, and a weak or

disputed professional knowledge claim (Beddoe, 2010: 106). Social workers in this small study demonstrated lack of a 'distinctive space'.

The social workers in this study sought to enhance their professional capital through education and the achievement of higher credentials. They felt thwarted by lack of autonomous decision making and a paucity of resources attributed to socio-economic forces, managerialism and a lack of status and the power to command funding for research and scholarship (Beddoe, 2011). The preoccupation with making comparisons between social work and other professions speaks to a profession lacking the confidence of the 'distinguished possessor' and more of the anxiety and uncertainty of the 'pretentious challenger' (Bourdieu, 1984: 251).

Olgiati (2006: 541) observes that the connection of a profession to a particular type of academic knowledge is a common factor in defining professions and an expanded education 'is at the core of the rise of professionalism. Yet a political strategy of professional closure is the leading rationale of professional action' (Olgiati, 2006: 541). Perhaps this is where health social workers were located at the time of the study: using the best strategy available to them in this current era when registration of the profession was new and subject to some ambivalence (Beddoe, 2010). The impact of the risk society and the associated rise of intense public scrutiny, plus concomitantly less trust in professions, has enabled social work to secure greater occupational closure via the regulation of the jurisdictional claim, thus raising symbolic capital. While this is a partial gain greater intellectual resource is seen as 'shoring up' the claim. As Healy (2009: 402) points out within the current 'new public management' regime, professions who can prove 'their capacity to manage risk through reference to a scientific evidence base', hold credibility while those who employ 'interpretivist or critical approaches to knowledge development … are vulnerable to devaluation'.

Study participants were concerned that social justice is weakened by the institutionalization of practice and note the potential capture by specialized work. Social workers are employed at critical sites of trauma, risk, recovery, grief and loss in hospitals/clinics and work with diverse beliefs and health and illness practices. Their comments suggest reinforcing engagement with non-medical knowledge; for example retaining a sociological perspective to ensure that practitioners recognize the potentially disempowering impact of risk work in health care (Fawcett, 2009). A critical perspective ensures that social workers recognize risk thinking as both a threat and an opportunity. Social workers can play a major role in picking up work with those politically defined as 'at-risk' and vulnerable populations. However if social workers buy into the risk paradigm uncritically they can contribute to social control systems, as noted in comments about the cloistering effect of being within the health system. The work of identity building requires a continuing engagement with critical ideas, often lost when immersed in practice imperatives.

Conclusion

This study suggests marginalization is still a feature of social work in the institutional health setting. Greater confidence in research and scholarship is identified as being important in developing a more secure claim to expertise (Beddoe, 2011). There is a need for further research to test the perceptions of other health practitioners about the role and value of social work. While there is clearly a lived experience of marginalization impacting on the perceptions of the social workers in this study, further education was identified as a strategy to address this. There is potential in better use of social workers' positions as insiders, gaining evidence used to advocate for policy and practice innovation (Beddoe and Harington, 2011). Social work has the data gleaned from experience at the front line to enable it to be a force for innovations that respond to the needs of diverse populations whose essential human rights are threatened by social inequalities in health (Bywaters, McLeod and Napier, 2009). Social work has a historical tradition of regarding any threats to health and well-being as being much more than disease and can work in primary care to attack the links between health and social inequalities. This perhaps signals a return to an earlier era, when practice was defined largely by public health imperatives and in the words of Todd (1919: 65) 'add a touch of literary varnish, and say that social work ought to stand for organizing scientifically the forces, personal and material of a community . . . to raise progressively the capacity of every member for productivity, service and joy in life'.

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