



Article

Perceptions of the social worker role in adult community mental health teams in England

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Abstract

There is a growing recognition of the importance of the social work contribution within community mental health services. However, although many texts describe what the mental health social work contribution should be, little empirical evidence exists about their role in practice and the difference it might make to service users. This qualitative study sought to articulate this contribution through the voices of social workers and their multidisciplinary colleagues via focus group discussions across four English Mental Health Trusts. These considered the impact of the social worker on the service user. Thematic analysis resulted in the identification of three over-arching themes: social workers own perceptions of their contribution situated within the social model; the high value their colleagues placed on social work support and leadership in a range of situations and the concerns for service users if social workers were withdrawn from teams. Key findings were that social workers are the only professional group to lead on the social model; that this model enhances the whole teams' practice and is required if service users are to be offered support that promotes long-term recovery and that without social workers, the community mental health team offer would be more transactional, less timely, with the potential for the loss of the service users' voice. If social work is to make a full contribution to community mental health team practice, it must be clearly understood and provided with the support to enable social workers to operate to their full potential.

Keywords

Mental health, social work practice, thematic analysis

Introduction

Social work has long been regarded as a core component of mental health support internationally. In England, social workers have routinely been members of community mental health teams (CMHTs) since the 1990s (Onyett, 2003) and recognised as one of a core group of professions working in multidisciplinary teams alongside medics, nurses, occupational therapists, psychologists and support workers (Huxley et al., 2011). Their role and contribution to these teams, however, is often described as unclear (Woodbridge-Dodd, 2018) and their potential as 'under-developed' (Allen, 2014: 5). Reasons given for this include the complexity of the social work role, the dominance of the medical model within mental health (Gould, 2010) and the rise of generic roles within CMHTs, where professionals from a variety of backgrounds share a range of non-specialist tasks (Bailey and Liyanage, 2012) and, in England, the increasing statutory obligations of the profession (The College of Social Work, 2014). Additionally, the limited evidence of the effectiveness of integrated CMHT practice has potentially undermined the social work contribution as their membership has been regarded as a hallmark of an integrated team (Huxley et al., 2011; Wilberforce et al., 2011).

Social work is a complex profession, underpinned by specific values, skills and knowledge, including the social model of disability; communication expertise and command of legislation. In the mental health context, it seeks to promote long-term recovery: the rebuilding of a 'worthwhile life' for service users through gaining control, being connected socially, having valued social roles and positive self-identity (Tew et al., 2012: 444). Definitions of social work are also complex as well as 'contested and evolving' (Moriarty et al., 2015: 3). This can make it difficult for those outside the profession to understand what social workers do or how they add to an individual's care (Larkin and Callaghan, 2005; Woodbridge-Dodd, 2018). Some evidence suggests that even social workers find their role challenging to explain (Morriss, 2017; Roysum, 2017). In a description of findings from interviews with social workers seconded to CMHTs, Morriss (2017) reported that participants struggled to positively articulate their role, describing it as 'operating in the gaps left by other professions' (1348). Others have suggested that social workers believe that *how* they undertake their role is more important than *what* they do (Roysum, 2017). Social workers within CMHTs have been found to undertake a range of roles and tasks including assessment and care coordination, therapeutic interventions, support to access a wide range of services, the management of complex multi-agency meetings and provision of support under the auspices of mental health legislation.

In 2014, The College of Social Work, set up to represent, strengthen and support the profession, and operational between 2012 and 2015, published five key areas of practice for social work in adult mental health. These are: enabling people to access advice and support to which they are entitled; promoting a personalised social care ethos and discharging statutory duties; promoting recovery and social inclusion; providing professional leadership and skill in complex, risky and ambiguous situations; supporting individuals and communities around resilience and active citizenship and leading the Approved Mental Health Professional (AMHP) workforce, additionally qualified social workers and other professionals who undertake a range of roles authorised by mental health legislation. The document also noted the importance of local government (typically social workers employers), health trusts (where mental health social workers are often based within multidisciplinary teams) and service commissioners, in promoting the crucial role of social workers in the mental health sector, stressing that such recognition cannot be taken for granted (Allen, 2014).

This is in part due to the dominance of the medical or biomedical model in mental health practice which remains a challenge for social workers, schooled in the values of social models (Wilson and Kirwan, 2007). Whilst the 1970s and early 1980s saw the rise of the biopsychosocial model in psychiatry, it has been argued that a 'bio-reductionist orthodoxy' has since re-emerged (Gould, 2010: 17). Nevertheless, more recently, a growing recognition of the importance of the social determinants of mental health has been seen both in England and elsewhere (e.g. Royal College of Psychiatry, 2014; World Health Organisation and Calouste Gulbenkian Foundation, 2014) with recommendations in England for the social

model to be implemented more widely (All Party Parliamentary Group on Social Work (APPG), 2016). Whether this represents renewed support for social workers as core CMHT members is less clear. Some evidence exists to support this aim, in particular demonstrating that where social workers are present within CMHTs, the quality of care is improved (Abendstern et al., 2014; Huxley et al., 2011; Wilberforce et al., 2016). However, evidence remains limited (Moriarty and Manthorpe, 2016) with voices from within the profession expressing concern that an evidence base is required to demonstrate the relevance of social factors and social interventions to mental health recovery (Tew et al., 2012; Woodbridge-Dodd, 2018).

A complicating factor in evaluating the role of social workers in integrated CMHTs has been the rise of generic roles within these teams in England (Brown et al., 2000) which may have attenuated the social worker role (Rapaport, 2005) and increased its susceptibility to being undermined as a specialism (Bailey and Liyanage, 2012). Policy reforms that challenged traditional ways of working in CMHTs largely ignored the social work contribution (Department of Health (DH), 2007). More recent reports, however, have noted that social workers were often used generically, their skills wasted, to the detriment of service users (e.g. Lilo and Vose, 2016). Whilst some evidence suggested that professionals were more concerned to do what needed to be done rather than stick to their professional role (Hannigan and Allen, 2011), genericism was usually reported to result in professional entrenchment rather than the desired outcome of a boundary-spanning workforce (Oliver, 2013). Their perceived misuse as generalists rather than specialists in CMHTs has led to role conflict among social workers (Carpenter et al., 2003) and, in England, to their local government employers questioning their position as CMHT members. Anecdotal evidence of social workers being removed from CMHTs in England to relocate within local government Social Service Departments is growing (Gilburt et al., 2014; Moriarty et al., 2015).

It is within this context of limited role clarity and value that the current study is located. The aim of this paper is to identify and explicate the contribution of social workers to CMHTs and their perceived impact on service users.

Method

This qualitative paper forms part of a larger-mixed methods study that aimed to identify the social work contribution to CMHTs drawing on the characteristics, opinions and experiences of managers, practitioners and service users (Boland et al., 2019; Wilberforce et al., 2019). The views of social workers and their team colleagues were collected via focus groups and analysed using Braun and Clarke's organic thematic analysis method (2016). The study was supported by a Lay Reference Group of seven people who were either carers of people with mental health difficulties or were mental health service users themselves. The group met regularly throughout the study and assisted in the conduct of the research, the interpretation of the findings and their presentation. They played a key role in the

orientation of the focus group discussions to incorporate a service user perspective. Participants took part in a sense-making exercise where initial findings were presented in terms of key issues raised by groups. Participants were asked to consider whether findings resonated with their experiences. The outcome of this process was used by the research team in further analysis to refine and construct the final themes.

Sample

Participants were drawn from four NHS Trusts in England. Two served inner city populations and two described themselves as serving a mixture of urban and rural communities. At the time of data collection, one trust included age inclusive teams for people with functional ill health. In three Trusts, social workers were team members, and in the fourth, social workers had been removed within the previous year into separate social care pathway teams. Participants were contacted and invited to take part via their Trust's Research and Development team. All team members, including support workers, were eligible. Whilst the presence of managers might have inhibited more junior staff, we did not exclude the possibility of team manager involvement, as the issue under discussion did not relate directly to management issues. Team managers were consequently regarded as experienced practitioners of relevant professions. Prospective participants were sent an information sheet, and informed consent was obtained in writing from individuals prior to each focus group.

Data collection

To move beyond a discussion of what social workers do and to elicit from participants the perceived effect on service users of their presence or absence, they were asked to consider the impact of social workers on service users and any potential loss to teams if they were no longer included. The question posed to each group was therefore: What would be lost to service users if social workers were not team members? The broad scope of this question lent itself to the focus group method, recommended where a group process can 'illuminate' a research issue and where members can work together to consider the topic and share their views (Lewis and Nicholls, 2014: 56). A strength of this method is that, in contrast with individual interviews, interaction between group members can generate a richer data set with individuals responding to and building on themes initiated by each other (Finch et al., 2014). Conversations are not rehearsed, and although their occurrence is constructed, interaction is naturalistic, as in everyday conversation where people are influenced by those who they are talking to (Krueger and Casey, 2009). Interactions within groups can also be challenging, for example, when faced with dominant voices and inter-group conflicts or due to the tendency towards normative arguments. It is important that facilitators are alert to these issues and able to manage them constructively within the data collection and during analysis processes (Smithson, 2000).

The optimal composition of groups to promote open discussion is between six and eight plus a facilitator (Finch et al., 2014). Some diversity is thought to be

beneficial to stimulate discussion alongside a level of commonality to create trust within the group. For the current study, six groups were undertaken across three of the four trusts. Groups were divided into two types: social worker only and other CMHT professionals. Members of individual groups worked within the same NHS Trust. Some worked in the same teams. All knew at least one other member of their group. The fourth Trust (one of those with social workers in their CMHTs) was unable to bring a group of social workers together due to staff shortages whilst only one person turned up to take part on the allotted day of the other professionals group. The facilitator was a member of the research team (MA). A second member of the research team (SB/RP) was present to act as timekeeper and to support the process through attending to late comers and collecting consent forms. Ground rules about confidentiality were set at the start of each group and a summary of the process described. Groups lasted between 35 and 55 minutes.

Data analysis

A thematic analysis was undertaken, using Braun and Clarke's (2016) 'organic' approach, whereby themes are 'crafted' (740) by the researcher through reflection and interpretation of the data, forming a representation of the researchers' understanding of the data. Analysis was inductive, being data rather than theoretically driven. Codes, concepts and themes were developed throughout the analysis process, moving from semantic description to interpretation with the aim of conceptualising 'the significance of the patterns and their broader meaning and implications' (Braun and Clarke, 2006: 84). Subjective understanding is acknowledged within this method. Frequency of views is of less significance than relevance within this approach meaning that minority views that express issues closely related to research questions are just as important as identifying consensus within the data. The practice is iterative, rather than linear, with refinement of ideas throughout the analysis process. Braun and Clarke's (2006) six-stage process of familiarisation, initial coding, searching, reviewing and defining themes, and producing the report was used. This process was undertaken by the lead author in the first instance with periodic discussion to challenge, modify, develop and reach consensus, with other co-authors who were familiar with the data through their presence during data collection or through their reading of transcripts. The coding system can be seen in a supplementary document (available from the journal).

Ethical approval for this study was granted by the North of Scotland (2) Research Ethics Committee: grant number: 17/NS/0127. All participants provided written informed consent.

Findings

Thirty-five staff participated in the focus groups of whom 20 were social workers. The non-social worker groups (from here on referred to as CMHT colleagues) comprised a mix of largely mental health nurses and occupational therapists with a

Group type	Group ID	Participant ID
Colleagues	1	1.1 – 1.5
Social workers	2	2.1 – 2.6
Social workers	3	3.1 – 3.7
Colleagues	4	4.1 – 4.4
Social workers	5	5.1 – 5.7
Colleagues	6	6.1 – 6.5
Colleagues	7	7.1

Figure 1. Group and participant type and ID.

smaller number of psychologists and support workers. Two of the three social worker groups included a team manager who was also a social worker. Team managers were also present in two of the CMHT colleague groups (representing occupational therapy and mental health nursing) with two present in one group. Most participants were female (ratio of 28:7). A breakdown of group membership which protects anonymity is presented in Figure 1.

Data analysis resulted in the construction of three major themes: (i) social workers' self-conception of their contribution, including distinctive underpinning principles and values; (ii) CMHT colleagues' understanding and valuing of the social worker role and (iii) the perceived implications of the loss of the social worker contribution to CMHTs for service users. Each theme contained sub-themes, summarised in Figure 2.

Social workers self-conception of their distinctive contribution

Social workers perceived themselves as making a distinctive contribution to the work of CMHTs, ensuring service users were seen 'in the round', accessed support and were enabled to achieve long-term recovery. They distinguished themselves from their team colleagues in terms of their understanding of the social determinants of mental ill health and their approaches to overcoming these. This was explained as bringing to their role an understanding of how, for example, poverty and discrimination affected mental health (e.g. leading to social isolation) and the skills and knowledge to work with people to ameliorate negative impacts. The example below illustrates this emphasising the differences between the social worker approach and other professionals who employ a medical model:

We work in a long-term model of empowerment, so we're building strength and resilience, and we're working to long term recovery. So if you're looking at the medical model, it's very short term isn't it... [Social work is] about the long term stuff,

increasing choice and control . . . you get all of those social factors in place and people are more resilient . . . it can't just be contained in a hospital admission, medication. (Social worker participant 2.3)

Whilst social workers undoubtedly undertook ‘tasks’, they emphasised that their rationale and approach to these was always at the forefront of their practice. In relation to supporting someone’s housing application, for example, one social worker remarked that this task went far beyond helping to complete an application to looking more deeply at how their housing situation might be contributing to a relapse in their mental health and supporting them through this. Their remarks suggested both tacit knowledge that understood complexity within the mundane and the use of sophisticated tacit skills such as communication and relational practice that could appear routine:

There’s something about communication skills that comes into our role that’s quite complex . . . Sometimes it can just be a normal visit and there’s lots that’s thrown up at you and you have to think about in reflective practice . . . that’s just your day to day kind of care planning with your service users. (Social worker participant 2.2)

Social workers also described themselves as using relational approaches to build trust and rapport and of keeping the ‘wishes and feelings’ of the person

Main theme	Subthemes
Social workers self-conception of their distinctive contribution to CMHTs	Using value-based approaches to achieve long-term recovery
	Prioritising relational practice
	Challenging colleagues to ensure the rights and wishes of service user are respected
	Positive risk taking
Colleagues’ perception of social workers’ role and value in CMHTs	Social workers apply social model
	Social workers provide guidance and leadership regarding procedures for complex casework
	Social workers enable other practitioners to provide enhanced practice
Perceived implications of loss of social workers to CMHTs for service users	Holistic practice would be lost and a transactional model would dominate in teams
	Delayed recognition and support of social needs for service users and carers
	Loss of service user voice and perspective championed by social workers would lead to more limited responses

Figure 2. Themes and subthemes.

(Social worker participant 2.3) at the centre of their work. To do this, social workers needed to achieve a deep level of empathy which they described as attaining through ‘walking in their shoes’ and ‘becom[ing] that person for that short while’ in order to understand the impact of an individual’s situation (Social worker participant 3.5). This required spending time with the person in their own environment, offering ‘positive regard’ (Social worker participant 2.6), ‘being present’ (a recognised condition within a therapeutic relationship (Geller and Greenberg, 2012)), listening to them and asking questions to get beyond their immediate presentation. Comments from social workers (and their CMHT colleagues) suggested that they were the only professionals who had the time to undertake such work. For example:

We’re...less willing to give up on somebody... The medical model is much more ‘two shouts and...you’re out’. [We’ll] work with the person and we can see all the pressures because we’re going to their home environment and we can see what they’re under. (Social worker participant 3.4)

Social worker participants described their role as a ‘bridge’ between the service user and other professionals within the team, advocating for the service user to ensure that their rights and wishes were respected. They used language such as ‘fight[ing] their corner’ (Social worker participant 2.4), being ‘persistent’ (Social worker participant 3.4) and ‘challenging’ medical opinion and ‘being their voice’ (Social worker participant 5.5). One commented that:

Part of our role is obviously to promote their rights and give them the information and advocate on their behalf... and I think we’re really good at that. (Social worker participant 3.4)

Finally, social workers described themselves as being more tolerant of chaos and uncertainty than their team colleagues, something that enabled them to dispel crises. Commenting on this issue, one social worker noted that ‘we can say okay, let’s not panic, let’s just try to contain the situation’ (Social worker participant 3.1). This was expressed as an ability to ‘sit’ with crises and reflect on challenges with the aim of finding alternatives that took individual’s strengths and wishes into consideration, an approach referred to as ‘positive risk taking’.

CMHT colleagues’ perceptions of the value of social workers to the wider team

CMHT colleagues recognised the centrality of the social model to the social work role. They spoke of social workers having a ‘wider perspective’ (CMHT colleague participant 1.4) than other CMHT members, involving going ‘back to the causes...the things that the medical model just don’t realise’ (CMHT colleague participant 4.2) and looking at ‘what might have happened to that person that might have led to the situation that they’re in’ (CMHT colleague participant 1.4). This perspective was valued by them as helping to enhance their thinking and

practice beyond the immediate medical issues. They also valued what they described as social workers broad knowledge and skills that could lead to improvements in their own practice in terms of: timeliness, person-centred and holistic approaches.

There was a recognition from all participants that a working knowledge of a range of 'generic' tasks was required of all care coordinators working in CMHTs. However, such work was reported to be undertaken with more confidence and efficiency where there was access to specialists (in this case social workers) for advice and support relating to social care.

I'm trained as a CPN, and my focus mainly is...on the effects and side-effects of medication...I still have to deal with housing issues...I feel confident when I have a specialist in the team that I can ask, and validate whatever I'm doing. (CMHT colleague participant 6.2)

Immediate access to social workers was perceived as improving the timeliness of support, for example, in the case of a hospital or prison discharge.

It was so helpful having them there... knowing which other agencies around domestic abuse I could contact and what forms I had to fill out to carry that process forward... It was great having someone in my office who sits next to me who's so knowledgeable...It's kind of time sensitive because the person's abuser is coming out of prison. (CMHT colleague participant 1.2)

Those working in teams where social workers were no longer members described how their contact with the latter had changed, stating that this was now restricted to when 'directed or needed as opposed to that constant presence and awareness and involvement' (Participant 4.1). This was expressed as creating a more mechanistic relationship between social workers and their colleagues, requiring formal referrals and meetings to discuss cases that previously would have been known to them. This was said to create delay and additional work. In relation to Community Treatment Orders (CTOs – a statutory obligation), for example, which involved care coordinators writing periodic reports for case reviews, one colleague commented:

If they're already within the team...they'll know what's going on, on a regular basis...they would have already had all the background...It makes it so much easier than meeting up with them for a meeting, because the CTO is about to occur, 'cause that seems to be what happens now. (Participant 4.3)

Informal access to social workers was described as progressing work with individual service users, enabling CMHT colleagues to reflect on their practice, gaining insights and suggestions that helped them to move forward. For example:

That is massively valuable to me to have these brief discussions with them... it can throw the case in a whole different direction and usually a much more positive direction by having that discussion with them. (CMHT colleague participant 1.3)

Observing social workers in practice was also described as influencing the wider team, enabling others to think about 'the stuff that you don't even notice' that can 'influence then how you work' and help to understand that mental health is not 'just about conditions and illness' (CMHT colleague participant 7.1). This staff member went on to say how without being conscious of it, social work values 'filter [ed] down' in to how she practiced:

I'm always checking my responses when I'm working with somebody... why have I got that team involved?... Am I dis-enabling the service user by trying to put more care in? How do I work... to best empower that service user...? (CMHT colleague participant 7.1)

One voice within the sample took a more critical stance in relation to the social work contribution, arguing that their model fostered dependency. This person saw the role of the CMHT as one of identifying needs and either undertaking particular tasks to meet these or referring on to others to do so. In so doing, they maintained that those using services were put in charge of their lives.

Most of the individuals can do a lot of things for themselves but mental health services are doing a babysitting role... and I think the way services should be set up is to get people to... live more independently. You can't do that if you have a service that keeps people drawing back in (Participant 6.4)

This person's colleagues were critical of this view, arguing that the lack of social work team membership would lead to a poorer service for the public and additional stress and burden on them. These colleagues recognised their own value and foci and did not want to undermine this by taking on additional roles that were outside their scope of practice. These issues are considered further in the next section.

Perceived implications for service users of losing social workers from the CMHT

The contribution of the social worker to the CMHT has been positively identified in the two preceding sections. Participants also directly discussed the impact they perceived that the *absence* of social workers in the teams would have on service users. Concerns focused on three areas: the replacement of relational with transactional support, delay in recognition of social needs leading to less timely service delivery and a diminished service user voice and consequent adoption of more restrictive practices with a loss of social justice.

There was one alternative voice who took a critical stance regarded social work as one of many professions or agencies, like GPs and the police, to be called upon when needed. This person argued that where an issue required social worker input, a referral could be made and, consequently, there would be no loss to the service user.

Whether you are . . . contacting the GP or police or safeguarding team or whatever, a lot of it is these different teams working in different hubs, and when they need to get involved, they get involved and . . . life goes on. I think it might make more efficient use of services if people are simply completing the piece of work they have to do for that particular case. (CMHT colleague participant 6.4)

Other members of the group expressed concern about this view, arguing that social workers were central to the delivery of a holistic approach that was vital in supporting people to achieve long-term recovery. For example:

If we were to lose [social workers from the team] . . . we actually regress as a paradigm in terms of recovery model because we're going back into management of medical model type reduction strategies for treating mental wellbeing, rather than seeing the whole picture. (CMHT colleague participant 6.2)

The loss of social workers from teams was considered to compromise the identification of needs and access to support and recovery. This view was particularly evident among participants from the trust, where social workers were no longer team members. Social workers from this trust described a reduction in the discussions they had with the CMHT about assessments (e.g. for mental capacity), postulating that these were not taking place when required due to limited skills in this area of non-social work staff. These former social work colleagues recognised their shortcomings in relation to timely recognition of social needs leading to service delays.

I think we perhaps wait, and then a bit further down the line, we might think, oh yeah, this person might benefit from a Social Care Act assessment, and then things might have deteriorated . . . further than perhaps would have done had [social workers] been sitting in our meetings. (CMHT colleague participant 4.4)

Colleagues still working with social workers explained that without them, it was likely that service users would receive incomplete and poorer support, commenting that they may 'get left behind . . . have to wait longer' (CMHT colleague participant 1.2), receive services with 'holes' in them (CMHT colleague participant 6.2) and that their health 'might deteriorate' (CMHT colleague participant 1.3), making for both a less effective and efficient services. One participant stated:

It's not about they can't get that service, you can still refer them, but how long is it going to take you to do that? When you've got your colleague actually in the system, I

feel that it actually speeds everything up, and it's very beneficial to the service user.
(CMHT colleague participant 6.2)

The third issue of concern within this sample was that the service user's voice and perspective would be diminished if social workers were not present to advocate for them. All focus groups highlighted that social workers were the only profession prepared to challenge views and decisions dominated by medical or organisational pressures. For example, without social workers in teams, it was thought that decisions about hospital discharges and placements would be made on the grounds of cost, availability and the needs of the hospital rather than the individual and their family. Putting the service user first might mean delaying a discharge until an appropriate placement near family could be found, or considering alternatives to a hospital admission when an individual's health is deteriorating because they are not taking their medication.

A medic might say, well our option is, are you going to take the medication, no? So you're going to need to be in hospital then. A social worker might have different considerations... from a different angle. (CMHT colleague participant 4.2).

Social workers expressed concern that the right of the individual to make choices about their treatment and to be involved in the decision-making process would be undermined in their absence. An example in relation to a man who had stopped taking his medication indicated that CMHT colleagues focussed on the 'problematic' behaviour and medical solutions to it, whilst disregarding underlying issues:

So he was telling the doctor... I don't want to take it any more... And the doctor and the nurse were saying, well... he's older, he's not married, why does it matter? I said, but it does... he's telling you it's important to him. (Social worker participant 5.3)

Discussion

The findings from this study provide detailed evidence of social workers' unique contribution to CMHTs, identifying a distinctive value for services users and team colleagues. Their role was expressed in terms of both *what* they do in enabling service users' recovery and social inclusion, and *how* they do it by prioritising the relational element of working with service users. It was demonstrated that they undertake value-based practice that supports the whole team to adopt more holistic, person-centred approaches that assures added-value to both service users and team members alike (Penhale and Young, 2015). The findings are important in adding empirical evidence to the calls from within the profession and from both local and central government to preserve, enhance and support the social work role within CMHTs (e.g. Association of the Directors of Adult Social Services, 2017; DH, 2016). There was an alternative opinion suggesting that uncertainty about the

social workers' role in integrated teams may exist among other professionals. Three key findings, summarised in Figure 3, are discussed below.

The social workers' unique approach

The findings demonstrated a sophisticated articulation of the social work contribution by social workers and their colleagues, rationalising their role according to strong underpinning principles which oriented their contribution to a social model. Previous research into CMHTs for older people found that non-social work staff valued social work team membership for their specific skills, knowledge and values and in improving communication pathways within and beyond the team (Abendstern et al., 2014). Earlier studies also pointed to differences in social worker attitudes' compared with their colleagues that could influence CMHT service delivery. For example, social workers (and psychologists) were significantly less likely to support compulsory treatment compared with psychiatrists or nurses (Steinert et al., 2005), were more able to accurately identify complex social needs than nurses (Cestari et al., 2006), to be the ones to defend the rights of people with the most complex needs (Roysum, 2017) and to have the ability to recognise issues beyond the immediate (Morris, 2017). The current findings concur with these earlier reports, emphasising that social workers undertook distinct roles and tasks contingent upon specific social work knowledge, skills and values that encouraged more person-centred support.

Social work support to colleagues

The findings also indicated that the presence of social workers is important in supporting colleagues and enhancing the work of the whole team. Whilst others support the ethos and approaches taken by social workers, these are not necessarily central to their own work, and they were perceived to rely on social workers to keep the social determinants of health, the holistic approach and the rights and voice of the user central to practice. Peck and Norman (1999a) noted that social

Social workers provide a unique approach that ensures service users' individual needs are considered explicitly within the social context as part of a social model of care

Social workers' team colleagues rely on the support and leadership of social workers to ensure the implementation of the social model

The absence of social workers within the integrated team could result in slower, more fragmented support, with less personalised and socially appropriate arrangements available.

Figure 3. Key study findings.

workers were the only CMHT members reportedly challenging medics with nurses questioning whether they got tired of this role. Twenty years on it appears that they are still in this position. The implication is that if mental health services are to deliver social wellbeing and tackle the social determinants of mental ill health and social trauma, social workers need to be at the heart of integrated team practice. Recent legislative guidance in England has stressed the importance of integration between health and social care in mental health, citing social workers as playing a vital role in achieving this goal as leaders ‘both in their teams and across professional boundaries’ (Care Act, 2014: 1.30). The detailed evidence from social workers and their colleagues working in CMHTs in this study supports these statements.

Potential service user loss

The significance of the social worker role within mental health teams was emphasised in England by an APPG (2016). Their report stressed the importance of social workers in enabling people with mental health difficulties to achieve essential outcomes, such as protecting people’s rights and using solution-focused approaches to practical, emotional, health and legal issues. It stressed the lack of recognition and attention given to these crucial roles in policy or legislation, despite being ‘the things that people using services say are most important to their recovery’ (APPG, 2016: 3). The findings of this study add to weight to these statements. They demonstrated that without social workers in the CMHTs, users would be likely to receive a more restricted and transactional-based service which paid less attention to their rights and wishes and that access to appropriate support could be delayed with negative consequences for mental health. The question of whether social workers’ CMHT colleagues should incorporate a more holistic approach into their practice is also raised by this research. The vital but separate roles played by nurses, occupational therapists and other CMHT members was noted by participants in this and earlier research (e.g. Peck and Norman, 1999a, 1999b). Overall, the findings emphasise the need for CMHTs to have a range of skills and expertise available to service users that cannot be expected to be the domain of any single professional group.

Study limitations

First, the focus group approach has some strengths described in the method, but there are also limitations, which in the current study relate to the voices within the groups of CMHT colleagues. Although these contained some variety, the voices of nurses and occupational therapists dominated the discussions, possibly reducing the perspectives captured. Second, whilst our aim was to consider social work, the lack of discussion of the AMHP role is a potential weakness and should be addressed in future research. Third, the service-user voice is also absent from this study despite the question posed aiming to understand their experiences.

Other elements of the larger study of which this paper forms a part have addressed service users directly, examining their preferences with findings supporting those reported above, particularly in relation to the social workers' holistic perspective (Wilberforce et al., 2019). Future studies might also consider the implications of the social work role on carers as well as service users. Finally, although the statutory and organisational arrangements specific to England framed the focus group discussions, the findings relating to social work practices and approaches in relation to their direct work with service users and their support to colleagues are of international relevance.

Conclusion

The range of voices within this study offer an insight into the level of understanding and support for the social work role in this context. The critical voice alerts us to the challenges that may exist for social workers when their role is obscured and highlights the importance of nurturing and building its profile, protecting its specialist contribution within integrated settings. The findings provide strong evidence to support the continued presence of social workers in CMHTs as specialists, whose unique value-based approaches promote whole team practices that are valued by service users and team members alike.

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Supplemental material

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References

- Abendstern M, Tucker S, Wilberforce M, et al. (2014) Social workers as members of community mental health teams for older people: What is the added value? *The British Journal of Social Work* 46(1): 63–80.
- Allen R (2014) *The Role of the Social Worker in Adult Mental Health Services*. London, UK: The College of Social Work.
- All-Party Parliamentary Group on Social Work (2016) *Report of the Inquiry Into Adult Mental Health Services in England*. England, UK: British Association of Social Work.
- Association of the Directors of Adult Social Services and the Principal Social Workers' Network (2017) *Social Work: Essential to Integration. Advice Note (March)*. London, UK: Department of Health.
- Bailey D and Liyanage L (2012) The role of the mental health social worker: Political pawns in the reconfiguration of adult health and social care. *British Journal of Social Work* 42(6): 1113–1131.
- Boland J, Abendstern M, Wilberforce M, et al. (2019) Mental health social work in multidisciplinary community teams: An analysis of a national service user survey. *Journal of Social Work*. Epub ahead of print 8 July 2019. DOI: 10.1177/1468017319860663.
- Braun V and Clarke V (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(2): 77–101.
- Braun V and Clarke V (2016) (Mis) conceptualising themes, thematic analysis, and other problems with Fugard and Potts' (2015) sample-size tool for thematic analysis. *International Journal of Social Research Methodology* 19(6): 739–743.
- Brown B, Crawford P and Darongkamas J (2000) Blurred roles and permeable boundaries: The experience of multidisciplinary working in community mental health. *Health and Social Care in the Community* 8(6): 425–435.
- Care Act 2014, c.7. Available at: www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf (accessed 10 September 2019).
- Carpenter J, Schneider J, Brandon T, et al. (2003) Working in multidisciplinary community mental health teams: The impact on social workers and health professionals of integrated mental health care. *British Journal of Social Work* 33(8): 1081–1103.
- Cestari L, Munroe M, Evans S, et al. (2006) Fair access to care services (FACS): Implementation in the mental health context. *Health and Social Care in the Community* 14(6):474–481.
- Department of Health (2016) *Social Work for Better Mental Health – A Strategic Statement*. London, UK: Department of Health.
- Department of Health (2007) *New Ways of Working for Everyone*. A best practice implementation guide. London, UK: Department of Health and the Care Services Improvement Partnership.
- Finch H, Lewis J and Turley C (2014) Focus groups. In: Ritchie J, Lewis J, Nicholls CM, et al. (eds) *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. 2nd ed. London, UK: SAGE. pp.211–239.
- Geller SM and Greenberg LS (2012) *Therapeutic Presence: A Mindful Approach to Effective Therapy*. Washington, DC: American Psychological Association.
- Gilbert H, Peck E, Ashton R, et al. (2014) *Service Transformation: Lessons from Mental Health*. London, UK: King's Fund.
- Gould N (2010) *Mental Health Social Work in Context*. London, UK: Routledge.

- Hannigan B and Allen D (2011) Giving a fig about roles: Policy, context and work in community mental health care. *Journal of Psychiatric and Mental Health Nursing* 18(1): 1–8.
- Huxley P, Evans S, Baker C, et al. (2011) *Integration of Social Care Staff Within Community Mental Health Teams*. Final Report. Southampton, UK: NIHR Service Delivery and Organisation Programme.
- Krueger RA and Casey MA (2009) *Developing a Questioning Route. Focus Groups: A Practical Guide for Applied Research*. London, UK: SAGE.
- Larkin C and Callaghan P (2005) Professionals' perceptions of interprofessional working in community mental health teams. *Journal of Interprofessional Care* 19(4): 338–346.
- Lewis J and Nicholls CM (2014) Design issues. In: Ritchie J, Lewis J, Nicholls CM, et al. (eds) *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. 2nd ed. London, UK: SAGE, pp.47–70.
- Lilo E and Vose C (2016) *Mental Health Integration Past, Present and Future: A Report of a National Survey Into Mental Health Integration in England*. England, UK: NHS Health Education North West and Mersey Care NHS Trust.
- Morriss L (2017) Being seconded to a mental health trust: The (in) visibility of mental health social work. *British Journal of Social Work* 47(5): 1344–1360.
- Moriarty J and Manthorpe J (2016) *The Effectiveness of Social Work With Adults: A Systematic Scoping Review*. London, UK: King's College.
- Moriarty JA, Baginsky M and Manthorpe J (2015) *Literature Review of Roles and Issues Within the Social Work Profession in England*. London, UK: King's College London, Social Care Workforce Research Unit.
- Oliver C (2013) Social workers as boundary spanners: Reframing our professional identity for interprofessional practice. *Social Work Education* 32(6): 773–784.
- Onyett S (2003) *Teamworking in Mental Health*. Basingstoke: Palgrave Macmillan.
- Peck E and Norman IJ (1999a) Working together in adult community mental health services: An inter-professional dialogue. *Journal of Mental Health* 8(3): 217–230.
- Peck E and Norman IJ (1999b) Working together in adult community mental health services: Exploring inter-professional role relations. *Journal of Mental Health* 8(3): 231–243.
- Penhale B and Young J (2015) *A Review of the Literature; Public and Service Users' Opinions About the Conduct and Competence of Social Workers*. London, UK: The Professional Standards Authority.
- Rapaport J (2005) Policy swings over thirty-five years of mental health social work in England and Wales 1969–2004. *Practice* 17(1): 43–56.
- Royal College of Psychiatrists (2014) *Service Models in Adult Psychiatry. College Report CR188*. London, UK: Royal College of Psychiatrists.
- Roysum A (2017) 'How' we do social work, not 'what' we do. *Nordic Social Work Research* 7(2): 141–154.
- Smithson J (2000) Using and analysing focus groups: Limitations and possibilities. *International Journal of Social Research Methodology* 3(2): 103–119.
- Steinert T, Lepping P and Baranyai R (2005) Compulsory admission and treatment in schizophrenia: A study of ethical attitudes in four European countries. *Social Psychiatry and Psychiatric Epidemiology* 40(8): 635–641.
- Tew J, Ramon S, Slade M, et al. (2012) Social factors and recovery from mental health difficulties: A review of the evidence. *The British Journal of Social Work* 42(3): 443–460.

- The College of Social Work (2014) *The College of Social Work Guide to the Social Work Practice Implications of the Care Act 2014*. London, UK: The College of Social Work.
- Wilberforce M, Harrington V, Brand C, et al. (2011) Towards integrated community mental health teams for older people in England: Progress and new insights. *International Journal of Geriatric Psychiatry* 26(3): 221–228.
- Wilberforce M, Tucker S, Brand C, et al. (2016) Is integrated care associated with service costs and admission rates to institutional settings? An observational study of community mental health teams for older people in England. *International Journal of Geriatric Psychiatry* 31(11): 1208–1216.
- Wilberforce MR, Abendstern M, Batool S, et al. (2019) What do service users want from mental health social work? A best-worst scaling analysis. *British Journal of Social Work*. Epub ahead of print 3 December 2019. DOI: 10.1093/bjsw/bcz133.
- Wilson G and Kirwan G (2007) Mental health social work in Northern Ireland and the Republic of Ireland: Challenges and opportunities for developing practice. *European Journal of Social Work* 10(2): 175–191.
- Woodbridge-Dodd K (2018) *Integrating Mental Health and Social Care*. England, UK: Centre for Mental Health.
- World Health Organization and Calouste Gulbenkian Foundation (2014) *Social Determinants of Mental Health*. Geneva: World Health Organization.