

Chapter 7: The role of mental health social workers in crisis work – values, responsibilities, powers, and duties.

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In this chapter, we will explore the role that mental health social work plays in crisis work. Social workers work within legal and policy frameworks, with duties and powers they fulfil. Social workers will sometimes, through these frameworks, be able to offer help and solutions to crisis situations. On other occasions, the statutory imperative that influences many aspects of social work practice might limit their involvement. The nature and circumstances of a person's crisis is very relevant to how a social worker will be able to respond, especially if they are employed by a local authority. This chapter will discuss how social workers bring their own professional skills and capabilities to support service users, carers, and colleagues to resolve crises, and in doing so, determine their role within a multi-disciplinary and interprofessional health and social care context.

Introduction

Qualified social workers work in various health, social care, voluntary, and independent settings. Nationally and internationally, they work with individuals, groups, and communities within society. Social workers in England and Wales must, by law, be registered with Social Work England (SWE) or Social Care Wales (SCW). The largest employer of social workers are local authorities who employ practitioners in children and families, adults, learning disabilities, and mental health teams. The last group is the focus of this chapter, as they are often working in a dedicated way to support people experiencing mental health difficulties.

However, social workers in any setting may well be part of a multidisciplinary or interprofessional team working with a family or individual. The majority of the time, mental health practitioners work in a supportive way fulfilling therapeutic and care management roles. In part though, these social workers remain agents of statutory control, playing a key role in the allocation of resources and through detaining and/or restricting the liberty of service users, as a consequence of assessments under the Mental Health Act (MHA) 1983 (2007), and/or the *Deprivation of Liberty Safeguards*, introduced as an amendment to the Capacity Act 2005.

Qualifying social work education programmes, registration with SWE or SCW, and optional professional membership with British Association of Social Work (BASW), if that is chosen, requires social workers to affirm that they will, like other professions, practice ethically and in line with professional values. These values for social work will be discussed later. For now, it is enough to note that in terms of a Bio-Psycho-Social holistic perspective, as to what contributes to and maintains poor mental health, social workers largely focus on the social and psychological aspects of that model. In this sense, social workers are focused more on the social determinants of health, and where change, adaptation, learning, or control is needed. The social perspective of mental health is distinctly different to the social model of disability (Oliver, 1983) but both place an emphasis away from purely biological, pharmacological determinism, which can dominate mental health practice more generally. Social work draws most of its knowledge and approach from sociology and psychology, framed in a desire to achieve social justice, promote human rights, and empower, so that positive change can be realised.

This chapter will examine in greater detail the value that mental health social work brings to crisis work, and the roles that social workers occupy in this pursuit. Firstly, the design of services where social workers are located is briefly reviewed. Then, the legislation, codes, policy, and guidance are noted, before a more in-depth consideration of the role in mental health social work is discussed.

Design of services

Mental health social workers work in a variety of settings, with approximately 5000 practitioners employed within local authorities, and 2500 employed or working within National Health Service (NHS) Trusts in England and Wales (NHS Benchmarking, 2020). A number of practitioners will also work in the voluntary, charity, and independent sectors. Social work services differ in their organisational design depending on a variety of factors. Most critical is the organisational relationship between the local authority and other organisations, principally the NHS, delivering local mental health services. Some local authority employed social workers will be members of multidisciplinary teams based within NHS mental health trusts. Alternatively, they may be members of adult care local authority teams. Approved Mental Health Professional (AMHP) qualified social work practitioners may be located in either setting, but the managerial responsibility for their work under the MHA 1983(2007) resides with the local authority.

Out of hours mental health services also vary in design and function. In some local authority areas, an Emergency Duty Team (EDT) service will operate. This service will be staffed solely by social workers who will respond to urgent requests for assistance for the whole range of adult and child care issues. This generic service design means that social workers are most likely to only be involved in mental health crises situations when a request for a Mental Health

Act assessment is made. For most other mental health crises, the generic emergency duty service will rely on other, extended hours, mental health service provision (i.e., Crisis Resolution and Home Treatment Team (CRHTT)) to assist service users and carers. In other local authority areas dedicated to out of hours, AMHP-only services are provided, with practitioners often being physically co-located with local out of hours mental health services.

In terms of crisis work in mental health care, social workers may be involved in several ways:

- Firstly, social workers are often members of multidisciplinary teams and, like their nursing and occupational therapy colleagues, will be care coordinators for the service users they work with. Depending on local arrangements, when known service users experience some form of mental health crisis, social workers will be involved in coordinating and delivering the appropriate response. This might be a direct intervention by the social worker and/or it might involve colleagues from other teams, professional disciplines, or services to support them.
- Secondly, social workers, especially those employed by local authorities (even if they are physically located within NHS Trusts) often have specific duties under the Care Act 2014 to undertake assessments of need for service users and carers, or respond to safeguarding assessments.
- Thirdly, mental health social workers will often have undertaken further specialist training to become an AMHP. This role is discussed in some detail throughout this chapter. While the social worker, an AMHP, may only formally be on duty to undertake MHA assessments on a given day, their knowledge and expertise about the appropriateness of statutory intervention in a crisis will always inform their work.

- Fourthly, mental health social workers, like their nursing colleagues, may have undertaken training to become Best Interest Assessors (BIAs) under the Capacity Act 2005. The extent to which this role is part of their daily working life within their teams will depend, amongst other factors, on how local adult care services are organised.

Legislation, codes, policy, and guidance

Local authorities provide services where there is a legal duty of care to do so. In this sense, resources are gatekept by local authority professionals to establish if that duty of care threshold has been met. Initially, this may involve an assessment or determination as to whether the local authority is the correct agency to be responding. For some assessments that the local authority undertakes (such as under the Children Act 1989, or Care Act 2014), an assessment has to be undertaken to establish if that duty is engaged for other legislation, such as interventions arising from the MHA 1983; where there is a 'reason to think' (s.13(1)) threshold which must be met before, for instance, a request for a MHA assessment would be accepted. Therefore, social workers are interpreting legislation, codes of practice, policy, and guidance to determine where there is a duty to act, relevant to that particular department's role and function. This can cause tensions, often when these processes, and the possible limits to what local authorities can offer, is not understood. In the following sections of this chapter, we will consider these differing frameworks and the professional roles. Familiarisation of these will assist the referrer to understand the criteria being applied to determine if a service, resource, or intervention might be offered by the local authority.

Typically, referrals can arise from:

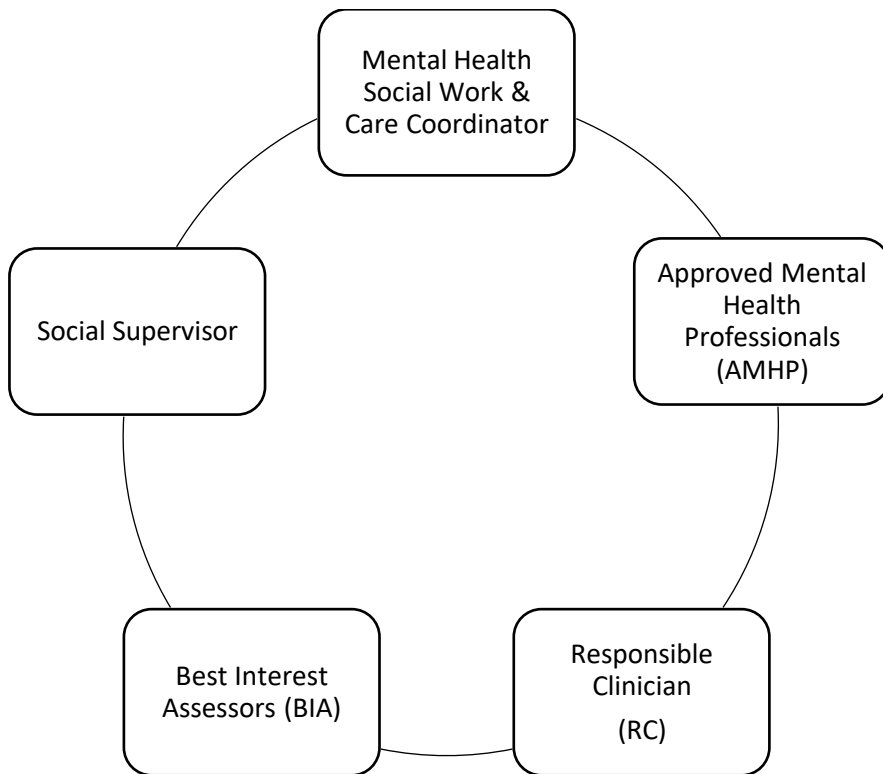
- Family and friends;

- General Practitioners;
- Police;
- Secondary mental health services such as CRHTT and Community Mental Health Teams (CMHTs);
- Places of safety, health-based environments, police stations, and others.

Referrals will be triaged to establish if the person at the focus of the referral is consenting to an assessment e.g. for a Care Act assessment, or if they have been deprived or restricted of their liberty, and require a statutory assessment under the MHA 1983(2007), such as s.136, or s5(2). S.136 MHA is a power a constable can use to remove a person from any place (other than any house, flat or room where that person, or any other person, is living) to a place of safety if it appears to the constable that the person is suffering from a mental disorder and is in need of care or control in the interests of that person or for the protection of other persons. The purpose is to enable them to be kept at the place of safety for an assessment under the MHA to be convened within 24 hours (this can be extended for 12 hours if it would not be practicable for the assessment to be carried out before the end of the 24 hours). S.5(2) MHA is a power a registered medical practitioner or approved clinician can use to detain an inpatient for up to 72 hours to enable an assessment under the MHA to be convened.

Lastly, a person may need assessing for detention in hospital in the interests of their own health and safety, or for the protection of others.

Roles in mental health social work



Involvement of local authority mental health services (including social workers) arises for a multitude of reasons. For example, support and care planning arising from Care Act 2014 assessments, where eligible mental health needs have been identified, or where signposting is needed to relevant community resources that do not require local authority involvement at all. Another area of practice relates to safeguarding adults. Although, as we have identified

the above design of services can differ, typically, mental health social workers are involved through a set of specific roles:

When engaging with a local authority for crisis work, some roles will be more readily visible than others, such as:

- **Mental Health Social Workers** - Care Act, 2014,
- **Care Coordinators** - under Care Programme Approach (CPA),
- **Approved Mental Health Professionals (AMHP)** - under the MHA 1983 (2007),
- **Best Interest Assessors (BIA)** - under the Deprivation of Liberty Safeguards / Mental Capacity Act 2005.

These roles are considered below. Social workers may hold several of the roles as part of their employment, but undertake them to a different extent or frequency, depending on the tasks their employer requires them to undertake.

Mental Health Social Workers / Care Coordinators

Mental health social workers (MHSW) work with service users or carers in the community, as a care coordinator or a case manager, typically overseeing a package of care or support to enable a person's eligible needs to be met. This may include duties under the Care Act 2014. As noted above, their location can differ, but which agency is involved will depend on which organisation has a legal duty to meet that assessed need. It is typical for post-registration social workers to begin their careers as care coordinators, before training for advanced roles such as AMHP and BIA. Mental health social workers may also engage in crisis work, through their roles in crisis teams and home treatment teams if they are employed by, or co-located

with, NHS colleagues. The challenge here is for social workers to maintain their social care / social perspective, while working within a predominately medical environment.

The two advanced roles that mental health social workers undertake are practicing as an AMHP and/or a BIA. Greater emphasis is placed in this chapter on these two roles, as their work is more frequently seen.

Approved Mental Health Professional - Mental Health Act work

Crisis Scenario: Some events in people's mental health crisis escalate to a point where a person may need to be assessed under the MHA 1983 (2007) to determine if detention in hospital is needed. Firstly, this might be if a person does not agree that it is appropriate for them to be admitted to hospital. Secondly, it might be if a person lacks the capacity, in relation to their care and treatment decisions, to agree to hospital admission when it is assessed by the appropriate doctors, and the AMHP, as being necessary. Equally, a person may be held to enable that assessment to occur, such as under s.136 or s.5(2) MHA 1983 (2007).

Background: Stone and Vicary (2020) note that AMHPs are responsible for coordinating assessments under the MHA 1983 (2007), and for making the application for detention if needed. An identical power exists in law for a person's 'Nearest Relative' but, in practice, this is rarely used. Although the AMHP role can be undertaken by mental health professionals from other disciplines, social workers make up 95% of the workforce (Skills for Care, 2021). When undertaking their duties, AMHPs may be located within their usual practice team setting, or may physically/organisationally move to an AMHP service located elsewhere. The AMHP service is sometimes located within a multi-disciplinary Crisis and Recovery Team, or, might be a stand-alone service within the local authority.

When AMHPs are responding to a crisis by undertaking a MHA assessment, they must adhere to the provisions of the MHA and the guidance offered in the English Mental Health Act Code of Practice (2015) and the Code of Practice for Wales (2016) respectively. In the MHA Code of Practice (CoP) are legal principles which must be followed, unless there are cogent reasons why adherence is not possible. These principles within the English code (2015) code are:

- **Least restrictive option and maximising independence**

Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible, a patient's independence should be encouraged and supported, with a focus on promoting recovery wherever possible.

- **Empowerment and involvement**

Patients should be fully involved in decisions about care, support, and treatment. The views of families, carers, and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

- **Respect and dignity**

Patients, their families, and carers should be treated with respect and dignity, and listened to by professionals.

- **Purpose and effectiveness**

Decisions about care and treatment should be appropriate to the patient, with clear, therapeutic aims, promote recovery, and should be performed to current national guidelines and/or current, available, best-practice guidelines.

- **Efficiency and equity**

Providers, commissioners, and other relevant organisations should work together to ensure that the quality of commissioning, and provision of mental healthcare services, are of high quality, and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe, and supportive discharge from detention. HMSO (2015)

The MHA and CoP are reminders of what Parliament intended, and how the judiciary have interpreted the provisions that Parliament set out. This means that there are limits to what an AMHP can legally achieve, and, also, due to the advanced training that they have received, why at times, those limits need to be reiterated to others who may feel that the MHA can be used (inappropriately) to find resolutions for a wide range of social ills.

Theoretically, a referral can arise from any source, although, in most cases referrers do not speak initially to an AMHP as front of house access is often staffed by administrators and call handlers. For a MHA assessment referral to be accepted, s.13(1) needs to be considered:

“If a local social services authority have reason to think that an application for admission to hospital or a guardianship application may need to be made in respect of a patient within their area, they shall make arrangements for an approved mental health professional to consider the patient's case on their behalf”

The 'reason to think' trigger is an important one when coupled with the principle above, relating to 'Least restrictive option and maximising independence', as this means that undertaking a MHA should be the last possible resort, and not the first. There are situations when a person is detained to a place of safety under s.136 by the police, or held in a place of safety under s.135 following removal from a property, where some form of assessment under the MHA is unavoidable. However, requesting a MHA Assessment should not be considered routine, and should certainly not replace a holistic mental health assessment undertaken by a crisis or home treatment, or psychiatric hospital liaison team. Therefore, although technically a referral for a MHA can arise from any person, unless the other alternatives can be discounted, a referral for a MHA assessment is likely to be declined.

The Articles of the European Convention of Human Rights (ECHR) (ECHR, 1950), the Convention on the Rights of Persons with Disabilities (CRPD) (CRPD, 2006), and other declarations or treaties need to be considered. As the ECHR articles were given direct effect in UK domestic law, through the Human Rights Act 1998, these must be considered in everything the local authority and NHS do as a 'public authority'. At the referral stage, Article 8 ECHR 'Right to respect for private and family life' subsections are important to consider:

- (1)** Everyone has the right to respect for his private and family life, his home and his correspondence.

- (2)** There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

(Article 8 ECHR, Human Rights Act 1998, Sch.1)

For these reasons, the AMHPs need to understand fully what has been tried, why an intervention at primary and secondary care has not helped resolve the crisis, and what the risks are if a MHA is not convened - in this sense, justifying the 'interference'. There can be a concern at this stage, by AMHPs, that risks can be exaggerated, or not sufficiently determined, so that a MHA can be gained. Also, AMHPs will want to establish that any physical causes for the mental disorder presentation have been discounted. Therefore, there will usually be a discussion at the referral stage to ensure that a MHA is necessary, proportionate, and justified. Requests for MHA assessments, with the exception of s.136 referrals, are not procedural and need to be investigated, because any resulting assessment may be intrusive and an interference with a person's Article 8 rights.

There may be safeguarding concerns associated with a mental health crisis, which fall under the Care Act 2014 and, as such, all agencies involved should make a safeguarding referral. Professionals should not assume or rely on the actions of the AMHP, or the provisions of the MHA in and of itself, to be the safeguarding response.

Approved Mental Health Professional - Mental Health Crisis Breathing Space

Crisis Scenario: Some people's mental health crises are, in part, caused by or feature, financial stress or debt. If a person in that situation is receiving mental health crisis treatment - not necessarily detention in hospital - then protection from enforcement action arising from debt creditors may be available.

Background: For people residing in England and Wales who need respite from debt, the Debt Respite Scheme (Breathing Space Moratorium and Mental Health Crisis Moratorium)

(England and Wales) Regulations 2020 offers protection. This includes provisions to temporarily stop action intended to enforce the debt, or, freezing charges or interest on their debt. To benefit from the mental health 'breathing space' scheme, an AMHP must certify that a person is receiving mental health crisis treatment, by submitting evidence to support a referral to a debt advice provider.

Best Interest Assessor under Deprivation of Liberty Safeguards

Crisis Scenario: In some scenarios people are subject to restrictions, such as living behind a lockdown, where they are not free to leave and are being constantly observed - or put in place - as those caring for them believe that they are acting to keep a person safe. In situations like these, in hospitals and in care settings, arrangements need to be assessed as to their legality, despite, perhaps, the best intentions - in most cases - of those implementing those restrictions.

Background: All professionals should be familiar with undertaking capacity assessments under the Mental Capacity Act (MCA) 2005, as this is a core part of all health and social care work, based upon the principles set out below, and the functional and diagnostic test. Our intention is not to discuss this here, but to focus upon the distinct role of the BIA. There needs to be a clear distinction made between the BIA-role, and persons undertaking assessments under the MCA 2005, as no mental capacity test outcome can authorise a deprivation of liberty.

As set out in Hubbard & Stone (2018), deprivation of liberty assessments will involve a BIA, undertaking functions under the Deprivation of Liberty Safeguards, to determine if a person's freedoms should be restricted to the point where that person is deprived of their liberty. The

BIA undertakes their work by completing an assessment of age, no refusals, and their best interests. The supervisory body (local authority) may also ask the BIA to undertake a mental capacity assessment, and an eligibility assessment, if the BIA-assessor is also an AMHP. These latter two assessments can be undertaken by a medical assessor (a doctor), who is s.12-approved under the MHA, alongside the mental health assessors' mental health assessment. The purpose of the assessment is to establish if the care that is in place is necessary to prevent harm occurring to the individual, and is proportionate to the identified risk of harm occurring.

When a BIA is undertaking their assessments, as with any one undertaking a MCA-assessment, the following principles apply for the purposes of this Act:

- A person must be assumed to have capacity unless it is established that he lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

The BIA role is largely undertaken by social workers, alongside their nursing, occupational therapy, and psychology colleagues. Any professional who is concerned that a person may be

deprived of their liberty without authorisation would make a referral to the local authority, if the managing authority, i.e. the place where the person is living, will not do so.

Approved Clinician / Responsible Clinician

Crisis Scenario: Some people who are subject to Community Treatment Orders (CTOs) - s.17A, MHA 1983 (2007) may need to be readmitted to a psychiatric hospital, due to a deterioration in their mental health. In this instance, their responsible clinician can initiate a recall of the patient to hospital and, if needed, revoke the CTO; thus, placing the person under s.3 once again. This negates AMHP involvement through setting up a MHA assessment, as the person to be recalled is already liable to be detained. No MHA assessment is needed.

Background: Since 2008, when the MHA 2007 was implemented, the psychiatry role of the 'Responsible Medical Officer' (RMO) was superseded by a new role entitled Approved Clinician. This new role can be undertaken by registered social workers, mental health and learning disability nurses, occupational therapists, and practitioner psychologists once the competencies required for the approved clinician role have been met (Department of Health (DH), 2017), following engagement with the appropriate training (Health Education England (HEE) 2020). In these instances, the mental health social worker is employed by the NHS to fulfil this role. The uptake of this new role has not been significant, as largely it requires support from the NHS Trust employers. Thus, the majority of Approved Clinicians acting as Responsible Clinicians are in the main registered medical practitioners.

Social Supervisor

Crisis Scenario: Some people who are subject to a s.37/41-MHA 1983 (2007) conditional discharge may need to be readmitted to a psychiatric hospital, due to a deterioration in their

mental health. In this instance, it is the responsibility of the medical and social supervisor to contact the Ministry of Justice's Mental Health Casework section to discuss whether the person should be recalled. Although a person subject to s.37/41 could be detained in hospital under s.2 or 3 of the MHA 1983 (2007), this would need careful consideration. If they are held under s.136, this would also need to be resolved first. The social supervisor is not necessarily a social worker, although they often are, and the medical supervisor is often their Responsible Clinician (see above).

Background: A s.37/41 is a court sentencing disposal by a Crown Court judge, usually following conviction of a serious indictable offence, or a defence of 'insanity' has been accepted as a defence for murder. The s.37 is a hospital order with a s.41 restriction order, which is often referred to s.37/41. If a mentally disordered offender is conditionally discharged by a tribunal (or by the Secretary of State), they remain on the s.37/41, but are now conditionally discharged into the community. In these circumstances, the person subject to this order will have a medical and social supervisor appointed to oversee them. See, also, MAPPA below.

Responsibility to onward referrals

As with all professionals, mental health social workers have an equal responsibility for making referrals to involve other agencies - to safeguard and protect. This can often include making referrals to:

- Adult safeguarding
- Children and Young People's services
- Multi-agency public protection arrangements (MAPPA)

- Multi-agency risk assessment conference (MARAC)

All of these referrals will engage a multi-professional health and social care response, involving the local authority, and can include involvement of the police. In some circumstances a direct referral to the police will be needed as lead agency.

Safeguarding Adults

Crisis Scenario: In the course of your intervention, you become aware that a vulnerable adult with care and support needs is experiencing, or is at risk of, abuse or neglect and, as a result of those needs is unable to protect them self against the abuse or neglect - or the risk of it (s.42: Care Act 2014).

Background: A safeguarding adults referral can result in a s.42 investigation, where the local authority must make inquiries or cause inquiries to be made. This work is undertaken in line with Chapter 14 of the Safeguarding of the Care and Support Guidance, issued under the Care Act, 2014 (DH 2014). Here, it also outlines typical forms of abuse that professionals need to be aware of, but does not offer an exhaustive list, recognising that new forms of abuse arise as societies' circumstances change and modernise. As set out in Spreadbury & Hubbard (2020), adult safeguarding is complex, but ultimately the purpose is:

"...to promote and support the human and civil rights of adults who are unable to claim, and are sometimes prevented from claiming, their own rights." (p,.1).

One key consideration in this pursuit are agencies sharing information so that a fuller picture of a person's circumstances can be understood, and appropriate action taken (s.45, Care Act 2014). Effective communication with the person to whom the concerns are focused is also

key. As such, most agencies also have a safeguarding lead who should also be informed of the concerns. Local authorities will have a Safeguarding Adults Board (s.43: Care Act 2014), whose purpose is “to help and protect adults in its area in cases of the kind described in section 42(1)”.

Liaison with Children and Young People's Services

Crisis Scenario: In the course of your practice, you become aware of a child in need and, as such, is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development, without the provision for them of services by a local authority. Their health or development is likely to be significantly impaired, or further impaired, without the provision for them of such services; or they are disabled (s.17 (10), Children Act 1989). Or, in more serious scenarios where you suspect a child may be suffering, or likely to suffer, significant harm. This includes child sexual exploitation.

Background: Contacting children and young people's services is an important step in gaining support for a family, and if significant harm is suspected, also gaining protective interventions through causing the local authority to make enquiries they consider necessary. This enables them to decide whether they should take any action to safeguard or promote the child's welfare (s.47 (1), Children Act 1989). The role for professionals is to report concerns (sometimes immediately to the police), and inform the family that they are making a referral. This can often be a difficult decision for professionals to make, but it is important not to collude with parents, but support them to recognise that the child is the paramount consideration. This means that caution should be taken by not adopting wishful thinking, or

embracing the rule of optimism by thinking everything will be resolved if a referral is not made. Or, worse, not referring because of an erroneous assumption that someone else will.

In the mental health context, placing emphasis on the protective aspect for an adult's mental health of having children, over the needs of the children's needs, must be avoided. Children being seen as a protective factor must not lead to that child not being brought to the attention of the local authority, or police in some instances. The needs of children must be given careful consideration in crisis work, given that children may be witnessing behaviours unusually uncharacteristic of their parents, or sustained stress at needing to take on caring responsibilities beyond their age and maturity.

MAPPA

Crisis Scenario: In the course of your work, a person who has been convicted of a sexual and/or serious offence, involving violence, may be referred to services. As such, under s.325 (3) of the Criminal Justice Act, 2003, professionals have a duty to work and cooperate with 'MAPPA responsible authorities', to manage the risk of eligible mentally disordered offenders (MHA, 1983 Code of Practice, 22.87); meaning that you should liaise with the police, or other agency, if the presenting risks are evident.

Background: The purpose of MAPPA is to reduce reoffending. So, a crucial part of this work is identifying offenders, and enabling coordinated information sharing. Multi-agency public protection arrangements (MAPPAs) exist to assess, and then manage, the risks posed by sexual and/or violent offenders through the interventions of the police, probation and prison services. The guidance (MAPPA, 2014) states that:

“The Criminal Justice Act 2003 (“CJA 2003”) provides for the establishment of Multi-Agency Public Protection Arrangements (“MAPPA”) in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders” (p, 1).

Identification of MAPPA-eligible offenders is the responsibility of each agency, including clinical commissioning groups and health trusts. A referral should be made to the single point of access; as agreed in each geographical area. This may be needed when an offender is subject to Level 1 monitoring, but new risk information suggests that this may need to be increased to Level 2 or 3 management. Referrals to MAPPA can be made by any Responsible Authority or Duty to Co-operate Agency.

MARAC

Crisis Scenario: In scenarios where you are concerned that, as a result of domestic violence, there is a serious risk of harm, - or worse, homicide - towards individuals or their families, a multi-agency approach will be needed.

Background: Although MARACs are not statutory bodies, local authorities can take a lead role. MARACs’ primary focus is to safeguard an adult victim of domestic abuse. The MARAC process involves making a referral to a multi-agency conference to enable information to be shared about a victim of domestic abuse to professionals from criminal justice agencies, such as the police and probation, alongside health and social care agencies, including housing and specialist Independent Domestic Violence Advisors (IDVAs).

Collaboration with stakeholders - service users, significant other, and other services

History and value of service user involvement in social work practice

Social work education and practice has always valued the contribution of people with lived experience of mental health issues. Their experiences, good or bad, have been important in informing the development of social work education and professional practice. Amongst other professions, social work has been praised for its progressive approach, especially in trying to include 'hard to reach' service user groups (Croisdale-Applyby, 2014). The social work role has been interpreted by some as a partnership between service user and worker, with the practitioner supporting the service users to make change, working with them in their community, promoting preventive work, and enabling them to address the problems that they face (Asquith *et al.*, 2005).

Social work perspective and holistic assessment

Social work practitioners are trained to undertake holistic assessments of service users' circumstances. Professional training teaches practitioners the value of the Social Model of Disability (Oliver, 1983), and how the barriers that society creates can have the most negative impact on someone's day-to-day life. The difficulties that people experience are not necessarily, or solely, illnesses, conditions, or disabilities, that are located within the individual. A holistic assessment enables practitioners to appreciate that it is the wider cultural and structural factors, as well as personal ones, that may impact on an individual's health and welfare (Thompson, 2020). There has also been a renewed emphasis on practitioners recognising the role of poverty (Cummins, 2018) on the people they work with, and of the role of other social determinants of mental health.

Social determinants of Mental Health

The social determinants of health are the “conditions in which people are born, grow, live, work and age, and inequities in power, money and resources” (Marmot 2020, p.1). This is the territory of social work, and this wider perspective on what contributes to crisis requires collaborative practice to help resolve crises.

The landmark study; *The Marmot Review, Fair Society Healthy Lives* (2010), confirmed unequal societies are more unhealthy societies. A gradient of health was established, that indicated that all members of society (apart from those at the very ‘top’) had worse health than they might otherwise have had because of the inequalities in housing, income, education, and health care that exists in society. Marmot was clear that it is the social and economic circumstances of a community, a town, a city, that have the most influence on the level of health inequalities. Reduce the gradient of the curve, and everyone benefits. Health inequalities apply to mental health as well as physical health. The social determinants of health have been described as the causes of the causes.

The social work profession has long been aware of the impact of social factors on people’s mental health (Bywaters, 2009). The Commission for Equality in Mental Health (2020) suggests that the inequalities in mental health can be framed in three dimensions - social and economic determinants, inequality of access to services, and inequality of outcome of the experience of using services.

In terms of crisis work, an understanding of mental health inequalities, and the social determinants of mental health, offer practitioners a more nuanced and rounded appreciation of the context and circumstances that may have led to an individual’s personal mental health

crisis. Collaboration - in the widest sense of the word - with community resources and services to support service users in crisis, is vital.

The crisis might have its antecedents in the social determinants of mental health. We all embody our lived experience of the circumstances that have impacted on our health (Krieger, 2016), and the crisis in a person's mental health will result, in part, from the cumulative toll that the social, economic, and environmental factors have had. Since the COVID-19 pandemic, the inequalities in society have been exposed afresh (Marmot, 2020), and the role of social determinants in contributing to people's experiences is even more evident (Marmot, 2021).

Collaborative working: professional sense or policy requirement?

Collaboration is a central tenet of professional mental health social work practice (Allen, 2014), and in mental health crises, its relevance is clear. As discussed, social workers practice in a number of different settings, and their ability to form good working relationships with other professionals is key. Collaboration involves the sharing of specific knowledge and skills to contribute to problem solving and crisis resolution. While legislation, such as the MHA 1983 (2007), and Care Act 2014, or policies such as the Crisis Care Concordat (DH, 2014), make collaborative working a policy requirement, it is also a key aspect of good practice - as discussed below.

Social work good practice

Values

Mental health social workers, practising in the circumstances of service users' crises, should continue to adhere to, and enact, the values of the profession. The international definition of

social work notes that it “is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people” (International Federation of Social Work, 2014, np). At the profession’s core is a concern for marginalised and oppressed groups within society. Many of the service users that practitioners have contact with will be from some of the most marginalised and oppressed groups in society, and a core concern for the profession is the welfare of those people.

Social work values are based on the respect for equality, worth and dignity of all people (BASW, 2014). Social work values refer to “a range of beliefs about what is regarded as worthy or valuable in a social work context” (BASW, 2014, np). This includes discussions about the principles social workers should follow in their work, and the desirable qualities of professional practitioners. There is no one specific list of values but the British Association of Social Work notes that they are embodied “in the profession’s national and international code of ethics” (BASW, 2014). They can be summarised as follows:

Human Rights

Social workers, through their practice, should:

- Uphold and promote human dignity and wellbeing.
- Respect service users’ rights to self-determination, to make choices and to make decisions.
- Promote people’s participation and involvement in services.
- Treat each person as a whole individual, who is part of a family, a community and an environment.

- Focus on the strengths of individuals, groups and communities to promote empowerment.

Social justice

Social workers, through their practice, should advocate for social justice by:

- Challenging discrimination on characteristics such as age, gender, sex, or ethnicity.
- Recognise diversity through understanding individual, family, group, and community differences.
- Distribute resources fairly and equitably.
- Work in solidarity with others to challenge social conditions that contribute to social exclusion and, in doing so, work towards an inclusive society.

Professional integrity

Social workers have a responsibility to:

- Uphold the values and reputation of their profession.
- Be trustworthy.
- Maintain professional boundaries.
- Make considered, professional judgements.
- Be professionally accountable for their judgement(s) and actions.

All social workers in the UK must be registered with their respective professional regulator in England, Wales, Scotland, and Northern Ireland. Each regulator requires its registrants to follow a professional code of practice, each of which highlights the importance of values and ethics in professional practice.

Social workers in mental health care, who are AMHPs under the MHA 1983 (2007), must also ensure that the principles set out in the MHA Code of Practice (2015) are adhered to. The principles apply across the professional roles for people who engage with the Act, such as psychiatry and mental health nursing. In particular, the principles link well with the social work values, but also apply to other approved professionals - such as nurses, occupational therapists, and psychologists - who undertake the AMHP role.

Collaboration

Social work has a long tradition of multidisciplinary and multi-agency working. Within mental health care, since the 1990s, social workers have often been members of multi-disciplinary teams working within NHS Trusts (Onyett & Campling, 2002). These experiences are not always straightforward. While valued by colleagues and service users, social workers have reported a relative 'invisibility', finding it difficult to define their role and expertise (Morriss, 2017). This is perhaps, in part, due to the generic nature of the Care Coordinator role (Bailey and Liyanage, 2012) but nevertheless, social workers can contribute particular expertise. Colleagues from other disciplines report that social workers:

- Apply a social model to their practice
- Provide leadership and guidance for complex casework
- Support practitioners to provide enhanced practice interventions (Abendstern, 2020)

Social work is often described as a values and relationship-based profession (Turney *et al.*, 2016), and this focus is welcomed by colleagues and service users. For social workers not based in multi-disciplinary teams, the importance of collaborative working is not diminished. In some areas of the UK, social workers will be employed in local authority-led specialist or

generic adult care teams, distinct from their NHS colleagues. Here, relationships between agencies and disciplines may be harder to engender, but it does mean that social workers are firmly rooted within local services. This gives them knowledge about, and access to, other services relevant to users and carers of mental health services; for example, knowledge about local statutory adult safeguarding services (Spreadbury & Hubbard, 2020). Similarly, some areas have standalone Approved Mental Health Act services, which sees AMHPs employed, managed, and located within local authority services. Collaboration is a key aspect of statutory MHA work, and an aspect of the AMHP role is to mediate between different services (Leah, 2019), often developing long lasting relationships with local general practitioners, psychiatrists, police, and housing services.

Resilience, reflection and the role of supervision

Service users in crisis may be experiencing great hardship and adversity. Practitioners, too, may find responding to the needs generated by those crises stressful. Mental health social work is a stressful occupation (Huxley *et al.*, 2005; Evans *et al.*, 2006), especially with regard to undertaking statutory tasks (Evans *et al.*, 2005). Successful social work is predicated on relationship-based practice (Ruch, 2005), and this focus on relationships suggests there must be a concomitant focus on the impact of working with emotions as an aspect of practice (Winter *et al.*, 2019). It is therefore important for practitioners to consider how they can maintain their own resilience and wellbeing.

Resilience is a contested concept focused on, in some way, how practitioners can manage their own wellbeing to meet the challenges of professional practice. A straightforward definition of resilience is 'an adaptive state and personality trait' (Collins 2007, p. 255) or that it denotes an individual's ability to 'bounce back' (Grant and Kinman 2013, p.357). Some

authors emphasise the importance of individual characteristics, such as enthusiasm and hope, as being important to develop or have, to maintain a personal resilience (Grant and Kinman, 2013). Other authors emphasise the promotion of organisational cultures and environments which promote their staffs wellbeing and resilience (Collins, 2017).

Reflective supervision is an established aspect of good social work practice (Fook, 2004), and it is a significant contributor to developing practitioner resilience within organisations (Beddoe *et al.*, 2014). The function of supervision varies between agencies and some may emphasise caseload management, but it is also the opportunity for reflective conversations that appears to promote the development of resilience (Collins, 2017). Timely and focused supervision, focusing, perhaps, on recent practice moments involving interventions at times of service user crisis, is important in supporting practitioners. Supervision enables practitioners to process their feelings about a particular practice moment, to reflect on the impact of their own role and identity on their practice, and to be reminded or reassert the professional values that guide their work. While many aspects of organisational working life are stressful, providing supervision is one intervention that employers can make, which can build practitioners' resilience (Ravalier, 2019) and create conditions that support practitioners to remain in role (Frost *et al.*, 2018).

Decision making

As noted above, social work practice is value-based and this informs practitioners' decision-making. Working with crises, whether undertaking statutory mental health assessment or not, it is important that practitioners can articulate how they make decisions. For AMHPs, though, the need to be able to make legally defensible decisions, regarding depriving service users of their civil liberties, makes this need all the more necessary.

Whether a decision is a good one or not is often assessed by its outcome. In crisis situations, the immediate outcome will usually involve an attempt to reduce risks, but the longer-term assessment of whether the decisions taken were there right ones, is harder to evaluate. In the current context of mental health practice, decision-making is often exhorted to be recovery-based and to promote individual responsibility for positive risk-taking. Involving taking calculated risks with service users and significant others, positive risk-taking aims to promote quality of life, and may lead to mitigating life-threatening risks like suicide (Reddington, 2017).

Social workers need to use their skills of critical reflection to inform their approach to practice (Fook and Gardner, 2007). Equally, critical analysis of the presenting issues is vital. Practice wisdom is the knowledge gained from practice, based on professional values and ethics, often in specific contexts. Linked with critical reflection, practice wisdom accumulates through experience and observation (Chu and Tsui, 2008). Social workers, like other professionals, will have developed expertise in coping with decision-making in crisis situations, which include incorporating a focus on their professional values, such as promoting self-determination, social justice and human rights.

An approach that supports social workers to do this is offered by O'Sullivan's (2011) 'Sound Decision Making'. It is suggested that, rather than evaluating decisions solely by outcome, the process of making decisions is also important leading to the proposal of six aspects of sound decision:

- Being critically aware of the practice context.
- Involving services users and carers to the highest level.
- Working collaboratively with others.

- Using knowledge, thinking clearly, and managing emotions.
- Framing decisions situations in a clear and accurate way.
- Analysing options and basing choices on reasoned analysis.
- Making effective use of supervision.

Social workers and other professionals can use this framework in crisis situations to help them make sure that the decisions that they may be about to take - the longer-term outcome of which may be unclear - can be grounded in good practice principles. It is a practical approach to promoting recovery-based interventions that promote service users' views and rights.

Conclusion

Mental health crises can take many forms, and require differentiated responses from mental health professionals. Social workers, typically employed in local authorities, play their part in multi-professional and interagency settings, to help resolve difficulties that service users' experience.

Social workers bring a value-base to their practice, explicitly predicated on autonomy, human rights, and challenging social injustice. Social workers also adopt a socially and psychologically informed understanding and response to mental health crises. This is not to discount the role of psychiatry and the medical model, but to acknowledge and balance the different ways in which mental health crises can be understood. In particular, the social work profession has an established tradition involving service users in the education of professionals, and the organisation of services.

The social determinants of mental health offer an understanding of the 'causes of the causes' of mental health crises, and can inform the social work response. Social workers are often

located in standalone services, or integrated NHS teams, with their multi professional colleagues. Their crisis response, role, and duties, in whichever setting, will fundamentally be determined by the legal and policy framework that informs the profession. This includes assessment and safeguarding responsibilities under the Care Act 2014. Most notably, though, many social workers will also have undertaken specialist training to undertake duties as an AMHP under the MHA 1983 (2007).

A mental health crisis that results in a statutory assessment under the MHA 1983(2007) will, almost by definition, be a very significant moment in a service user's life. An AMHP, typically, but not exclusively, social work qualified, following the values of the profession and the principles of the Code of Practice, will work to resolve the crisis in a way that respects, and is informed by, the views and wishes of the service user.

Further reading: -

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Golightley, M. & Goemans, R. (2020) Social Work and Mental Health (Transforming Social Work Practice Series) (7th Edition). Learning Matters: Basingstoke.

- **Mental Capacity Act and Deprivation of Liberty Safeguards legal framework:**

Hubbard, R. & Stone, K. (2018) The Best Interests Assessor Practice Handbook. Policy Press: Bristol.

- **Sociological Perspective of Mental Health:**

Rogers, A. & Pilgrim, D. (2020) A Sociology of Mental Health and Illness (UK Higher Education OUP Humanities & Social Sciences Health & Social Welfare), (6th Edition). Open University Press: Milton Keynes.

- **AMPHS:**

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<https://www.legislation.gov.uk/ukpga/2003/44/contents> <accessed 08/06/2021>

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https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf <accessed 05-02-2021>

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