# Working in greyscale:

## Understanding the role and position of social work in mental health services in England and Wales

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# Abstract

Social work in England and Wales has played an integral role in mental health since the formalisation of mental health care. However, neither the scope of provision nor the role itself have been clearly conceptualised, leaving contemporary mental health social work nebulously defined and unclearly situated within mental health structures. Moves toward and away from integrated care have contributed to role erosion resulting in a profession unclear of its position. Policy-led role definitions have been unsuccessful in addressing this.

Social work roles are deemed quasi-professional and difficult to articulate, highly susceptible to the external gaze of other professionals and to organisational expectations, which can prompt role defensiveness. However, understanding of the interplay of these factors in mental health is limited. This research adopted a mixed-method approach to establish an overview of mental health social work provision and to explore how mental health social workers perceive their role, accounting for variation and similarity across the range of practice contexts. An initial survey of mental health social work providers generated a framework to inform a survey of 248 social workers, thirty of whom also completed an in-depth semi-structured interview, exploring their views on professional identity and practice context. Data was analysed statistically and using a Framework thematic approach.

Participants articulated their professional role as an interaction of tasks, values and knowledge which informed a distinctive approach to practice. The externally facing, task-based roles were seen to be sensitive to practice environments and influences, but values and knowledge-based roles were presented as consistent across settings. This indicates a need for definitions of mental health social work to be distinguished from the activities of practice if this workforce is to be understood and deployed effectively. Further research to elucidate the values and knowledge base being employed in these roles would be beneficial in this.

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# Declaration

I declare that this thesis is a presentation of original work and I am the sole author. This work has not previously been presented for an award at this, or any other, University. All sources are acknowledged as References.

Material from this thesis has previously been published as a peer reviewed academic paper covering the initial work establishing an understanding of mental health social work provision, as detailed in chapters four and five. This paper is available from:

**Tucker, L., Webber. M. and Jobling, H. (2021). Mapping the matrx: understanding the structure and position of social work in mental health services in England and Wales.** ***The British Journal of Social Work. https://doi.org/10.1093/bjsw/bcab235***

Findings from this phase of the study were also used to support a report by Health Education England regarding a stocktake of the mental health social work workforce due to limitations imposed on their data gathering by the coronavirus pandemic. This report is available from:

**NHS Benchmarking (2020).** ***National Workforce Stocktake of Mental Health Social Workers in NHS Trusts.*** **Cambridge: Health Education England. Available from: https://www.hee.nhs.uk/sites/default/files/documents/NHSBN%20NHS%20Social%20Worker%20Findings%20for%20HEE.pdf**

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# Introduction

**Chapter 1: Introduction**

Despite occupying a key position within formalised mental health care from its inception, mental health social work in England and Wales has become nebulous and poorly defined (Wilson et al, 2011). Social workers in these contexts are employed predominantly within local authorities, and secondarily within the National Health Service (NHS), with their key roles and responsibilities deriving from the obligations of these organisations rather than from a clear professional objective. In recent years, there has been an increased awareness of mental health social work, led in part by promotion from within the profession (Allen, 2014), but reinforced through a governmental commitment to the ongoing training of specialised mental health social workers above and beyond the legislative role outlined in the Mental Health Act 1983 (HM Government, 2017), the adoption of profession-defined key roles into national policy (Allen et al, 2016) and the recognition of a need for an increasing social focus in mental health contexts (Department of Health, 2016). Despite this, the more general policy direction around modern mental health services is unclear about the discipline-specific contribution to service delivery and understanding the social work position within mental health has therefore remained challenging.

Research exploring mental health social workers' understanding and perception of their role undertaken by the researcher as part completion of a Master of Research in Social Work in 2017 highlighted an additional level of complexity in elucidating this understanding. While participants within that research were largely ambivalent about the policy-defined roles for mental health social work (Allen et al, 2016), it was also noted that key differences in perspective were linked to their working environment and corresponding job roles (Tucker and Webber, 2021). This was most starkly seen in relation to statutory duties, specifically regarding the Care Act 2014. Views on this were clearly delineated by employment setting. For those participants in local authority contexts, the duties put in place by the Care Act were seen as social work duties. By contrast, for those participants in NHS settings, the same duties were conceptualised as local authority duties which were enacted by social workers. The distinction here was critical; for one side, these statutory duties were integral

to the mental health social work identity, for the other, they were an external task that mental health social workers sometimes undertook.

Professional identity in organisational contexts is linked to a sense of belonging and an attachment to the position (Webb, 2017). Literature in this field suggests that identity is not only personal, but also relational; identity is defined not only by who the individual is but also by who others are and by how different identities interact across the organisation (Rasmussen et al, 2018; Ashforth et al, 2008). In this way, identity development is integrally tied to workplace influences and organisational cultures (Webb, 2017). Ashforth and Mael (1985) identified social identity (Tajfel and Turner, 2004) in organisations as necessitating elements of both self-definition and situational definition. Professional status could be defined in the context of three key characteristics: *distinctiveness*, drawing on intergroup comparisons to identify how the profession could be distinguished from others; *prestige*, covering the recognition and respect afforded to the profession and *outgroup awareness,* acknowledging that awareness of the other could reinforce the significance of the ingroup (Ashforth and Mael, 1985). In consequence, positioning professional identity in the workplace was presented as inherently contextual, where that context was both critical and influential in the final sense of identity which emerged.

Role and identity are similarly inextricably entwined (Best and Williams, 2017). While professional identity goes beyond specific tasks to encompass a fuller perspective on what that professional brings to their role, the distinctive mix of specialist skills and knowledge that a practitioner offers is argued to be a cornerstone of professionalism (Weiss-Gal and Welbourne, 2008). Joynes (2018), however, highlights that professional identity is a heterogeneous rather than a homogenous concept, with both internal and external drivers influencing how role is perceived and undertaken, and what responsibilities are in turn imposed. Variation within a professional group is therefore inevitable. However, where identity might exist more independently of context in principle, role is more environmentally driven. The expectations of the specific work to be undertaken are highly dependent on where it is undertaken, with a corresponding effect that role can widely differ subject to the workplace environment. This raises the potential for an over focus on tasks in

the absence of an overarching professional framework to dilute professional identity and in turn become a professional weakness (Nathan and Webber, 2010).

This is a critical consideration for mental health social work. As previously highlighted, social work in this field is positioned across a range of practice environments, including both health and social care. Social workers in mental health work across organisational settings; they can be situated within, as an adjunct to or separately from health-led mental health services and are employed by both health and social care-oriented organisations (Lilo, 2016). In a health-dominated and health-led environment, social work is prospectively a "'guest' in a host setting", with the associated risks of disempowerment which accompany this (Beddoe, 2017, p. 122). This suggests the need for a robust and clearly articulated sense of self in order to enable effective social work practice. However, the academic perspective on mental health social work, linked to ideas of social perspective and social intervention, has not translated well to the practice experience of mental health social work (Boland et al, 2019). Comprehensive and inclusive definitions of mental health social work remain elusive (Allen, 2014), with professional expectations highly variable (Peck and Norman, 1999). Definitions have focused on the 'what', the 'how' and the 'where' of practice, without reaching an effective consensus (see, for example, Abendstern et al, 2016; Buckland, 2016; Goemans, 2012, Nathan and Webber, 2010). Furthermore, research investigating the social work role specifically in mental health settings has been predominantly small scale and qualitative, frequently linked to individual practice contexts (Tucker and Webber, 2021; Bailey and Liyanage, 2012; Peck and Norman, 1999). The compounding influence of the variety in practice settings in mental health on the understanding of the professional social work role has been correspondingly underexplored.

This thesis therefore aimed to explore perceptions of professional role in mental health social work and how these are influenced by the practice context. Developing an understanding of the differences alluded to in previous research (Tucker and Webber, 2021) is critical in the wider societal context of mental health provision. Mental health services in England and Wales face increasing levels of demand. Need across countries is reported to be growing (British Medical Association, 2020; Welsh Government, 2019; Mental Health Foundation, 2016), with approximately 318,000 referrals per month and 1.4 million people

in contact with mental health services in England alone as at January 2021 (NHS Digital, 2021). This represents a 21% increase in demand since 2016 (British Medical Association, 2020). Although the coronavirus pandemic initially saw demand for services drop substantially in the early months of 2020 (NHS Confederation, 2020), early data indicates an increase in overall psychological distress in the population (Pieh et al, 2021; Pierce et al, 2020). Future need is predicted to increase across adults and young people, with an anticipated 10 million people requiring new or additional mental health support as a direct consequence of the pandemic, which is anticipated to include a strong social element (O'Shea, 2020).

Similar anticipations can be made around the current cost of living challenges impacting on a global scale. The expected negative impact of this on mental health and wellbeing has already been articulated (Anderson and Reeves, 2022), with previous experience indicating that social intervention will be needed to resolve this (Christodoulou and Christodoulou, 2013). Despite this, however, the lingering impact of austerity in public services is apparent and limiting (Farnsworth, 2021). Service provision is at static levels, while entrants to social work are reducing. Although qualification from specialist mental health programmes is remaining stable (Skills for Care, 2021a) information on retention of these practitioners within frontline practice is not yet available. Commitments to increase the mental health workforce (Health Education England, 2017) have not translated into additional staffing resources, with NHS staffing remaining stagnant or decreasing over the last decade (British Medical Association, 2020) and capacity detrimentally impacted by the coronavirus pandemic restrictions (NHS Confederation, 2020).

In the context of such restrictions and potentially limited resources, understanding the capacity and contribution of mental health social work to the overall provision of mental health care is therefore critical. Where demand is increasing but supply of the workforce is limited, making the most effective use of that supply is essential to provide the best quality of mental health care. However, evidence suggests there is both a lack of understanding of the structure and provision of the social work workforce itself (Health Education England, 2017) and a lack of understanding of the nature and contribution of social work to the mental health workforce (Woodbridge-Dodd, 2017; Allen, 2014). Mental health services in

England and Wales remain health-led and underpinned by a legislative framework that to at least some extent prioritises risk over rights (MacKay, 2012; Wilson and Daly, 2007), although early indications suggest that this stance may be shifting in light of the proposed revisions to the Mental Health Act 1983. Combined with the impact of local authority budget cuts, social work activity within the NHS has reduced (King's Fund, 2015), with mental health social work provision in some areas withdrawn to core local authority roles (McNicholl, 2016) in the context of no clear rationale to maintain social work specifically within NHS settings.

Social work's external positioning is a factor within this. While the components of the NHS workforce are well-documented, a similar overview of mental health social work at a national level is lacking (Anderson et al, 2021). Social work is not one of the distinguished professions within the NHS workforce return (NHS Digital, 2022) and social work regulators for both England and Wales do not monitor and report on the specialism which social workers practise within. This ambiguity may in part relate to social work's position within mental health. Social work straddles the boundary between health and social care, and the localised nature of local authority provision does not lend itself automatically to the same level of national oversight as the NHS. The haphazard nature of mental health social work provision is also a consideration. Evidence suggests that the development of mental health social work provision lacks intentional oversight, with the resulting practice reality demonstrating the absence of a targeted framework to structure this (Wilberforce et al, 2015; Burns and Lloyd, 2004). Although mental health provision is generally constructed using a range of allied professionals, including nurses, psychologists, psychiatrists, occupational therapists, and social workers, these latter are often seconded from local authorities (Gould, 2010) and actual team structure and composition appears to vary heavily by area (Freeman and Peck, 2009). The rationale for this level of variation is unclear, however key drivers appear to have been pragmatic, linked to local resource availability and convention and organisational priorities, rather than policy directives, intended outcomes or service aspirations (Boland et al, 2019; Lilo, 2016; Evans et al, 2012).

This apparent lack of direction may in part relate to mental health social work's organic rather than intentional growth as a profession. Contemporary mental health social work is

rooted in a combined history of formalised Psychiatric Social Work and local authority mental health services, the latter of which are frequently neglected in social work histories resulting in a limited and partial understanding (Burnham, 2011). Compounding this, the separation of social work and health in the 1970s following the Seebohm report (Seebohm Committee, 1968) positioned social work as a profession which held mental health responsibilities but sat outside the development and design of mental health services; a contradiction that remained in place until the turn of the twenty-first century. The narratives of social work and mental health ran as parallel but separate entities, creating a challenge for establishing either a social work space within mental health, or a mental health space within social work.

It is perhaps not surprising, therefore, that articulation of the social work role in mental health remains poor. Definitions of social work within mental health are both internally and externally situated and range across the practical, task-based (Dwyer, 2005; Morgan, 2004) and statutory (Abendstern et al, 2016) obligations, values and ethics informed practice (Goemans, 2012) and contextual positioning (Nathan and Webber, 2010). The academic literature defining the profession fails to reach a consensus, while policy-based definitions which intend to provide an inclusive overview of the role (Allen et al, 2016) have met with a lukewarm response from social workers in practice (Tucker and Webber, 2021). This is perhaps not surprising. While acknowledging the inherent influence of external perspectives in positioning professional status and defining professional roles (Rasmussen et al, 2018; McCrae et al, 2014), such external imposition of role can trigger "jurisdictional defensiveness" (Hannigan and Allen, 2011, p.6) wherein professionals attempt to defend and define their role against those external forces. Such definitions exist independently of the context in which they are intended to be enacted. Not unlike the use of traits to define a profession, this works on a process of normative standardisation which minimises the impact of the practice context (Dent, 2017) and exists in isolation from the needs and drivers of the wider health and social care settings. This is especially prevalent for social work, where the broad scope of its influence has historically been drawn from the state, within rigid legal frameworks for practice that do not fully capture the social analysis inherent in the profession. The relevance of such definitions can therefore appear limited to those expected to enact them. Critically, definitions of mental health social work need to

be reflected in and reflective of the experiences of frontline practitioners in order to ensure their effectiveness and relevance.

The focus of this thesis to understand and catalogue the position and intended contribution of mental health social work in its range of integrated and non-integrated contexts is therefore challenging. Current knowledge indicates a lack of clarity on what mental health social work is intended to achieve or where it operates, and a lack of consideration of the impact of the contexts in which it does so. Mental health social work appears shrouded in uncertainty; hidden within a localised system without clear oversight and with its contribution to mental health care ambiguously established. This thesis used a three-phase design which aimed to address some of these gaps in understanding. The overall aim of the research was to gain a clearer understanding of the position of social work within mental health services, and then to use this understanding to undertake a more comprehensive exploration of the mental health social work role, to compare how this differs across practice contexts, and to identify any common characteristics that could be said to define mental health social work more inclusively.

To achieve this, the research aimed to answer two primary research questions and two preliminary research aims. The primary research questions to be addressed were:

1. How do mental health social workers understand their role within mental health services?
2. How do employment circumstances and context impact on mental health social workers perception and undertaking of their role?

These questions were addressed using a two-pronged approach, combining a national survey of social workers in mental health with semi-structured interviews with a purposively selected sub-sample of the survey participants. The survey explored participant views on professional identity, the factors influencing this and experiences of the workplace context. The interviews, in turn, allowed opportunity for a more in-depth discussion of these role perceptions and how these were influenced by the surrounding contextual factors.

In order to achieve a broad and inclusive selection of participants, to represent views across the range of practice settings, a clearer understanding of the provision of mental health social work needed to be developed, acknowledging the existing shortfall in knowledge regarding mental health social work provision (Trewin, 2019). To achieve this an exploratory brief survey of mental health social work providers was carried out, with the intention of achieving the following two preliminary research aims:

- To establish a more robust estimate of the number of mental health social workers currently employed in England and Wales
- To establish where this social work provision is positioned within NHS and local authority settings.

The focus on the English and Welsh settings here was deliberate. As previously discussed, the state, and by extension, statutory obligation, has played a substantial role in the development of social work as a profession more generally (Dent, 2017). However, the statutory landscape across the United Kingdom is markedly varied, with Scotland, Wales and Northern Ireland operating with health and social care systems which are to varying extents devolved from those in place for England (Gray, 2021; Brodie et al, 2008). The lack of consideration of practice context in any setting in the UK suggested that an in-depth exploration of how mental health social work had developed and was applied across the full range of these jurisdictions was likely to be overly complex and risked obfuscating the influence of practice setting behind the variation in legislative context. England and Wales were chosen for this research, in part as the phenomenon of difference had initially been seen within research in an English context (Tucker and Webber, 2021) and in part due to the close links between the English and Welsh legislation which has resulted in a mixture of shared and devolved legislation (Scourfield et al, 2008) distinct from that of the other UK nations.

Initial reviews of the literature relating to the history and development of mental health social work, and the significance of professional role in social work and the associated mental health professionals illuminated a complex tapestry of research, theory, legislation and policy which provided the foundations for current understandings of mental health

social work within the UK. The initial chapters of this thesis therefore aimed to generate a comprehensive narrative to make sense of this and to provide a framework of understanding within which to position the subsequent empirical work.

**Chapter one** establishes the historical context for mental health social work in England and Wales, weaving the previous existing histories of mental health and social work development to provide the specific historical threads to understand this sub-specialism in social work. This chapter charts the history of the profession from the late nineteenth century, with an exploration of the social, legislative and policy influences that helped to shape it through to the modern day. It concludes with a consideration of the importance of devolution in changing the practice environment and the future implications of current developments in the mental health landscape.

Having established this background to practice, consideration then turns to the concept of professionalism both specifically in social work and more broadly. **Chapter two** explores the concept of the professional in the light of underpinning theories of Social Identity, Role Theory and Social Role Valorization. It considers how professionalism is applied to social work and, by comparison, more widely to a range of allied health professionals, before addressing how wider social influences, such as austerity, can impact on the enactment of professional identity. **Chapter three** in turn narrows this focus specifically to the social worker in mental health contexts, to look at the impact of the multi-disciplinary environment and the health-dominated provision on mental health social work professional identity.

The subsequent chapters report on the preliminary stage of the research. Acknowledging the criticality in understanding how mental health social work is structured in England and Wales in order to subsequently explore this in a comprehensive fashion, **chapter four** presents the methodology and explores the ethical issues for the exploratory survey of mental health social work providers, including all NHS trusts and Local Health Boards with the responsibility for providing mental health services and all local authorities in England and Wales with the responsibility for providing social care. **Chapter five** correspondingly details the findings from this survey, to give an overview of the number and location of

social workers working within mental health across England and Wales, and a consideration of structural factors which might influence the composition of these services, including organisation types, organisational interactions and location.

Drawing on these findings from the exploratory survey, **chapter six** presents the methodology for the subsequent two phases of the research: the national survey of mental health social workers and the in-depth interviews with the purposively selected sub-sample of these participants. The methodological considerations for both elements of the research design are explored in detail, including participant recruitment, data collection, analytic approaches and ethical issues for each aspect. Additionally, the ethical implications of undertaking research in health and social care settings in the context of the demands of a global pandemic are explored in detail.

The following three chapters focus on the findings from these two aspects of the research. Firstly, **chapter seven** details the overview of participants' responses to the survey in relation to professional identity, the factors which influence this and their experience of the practice environments. These findings are subsequently analysed to explore how demographic characteristics and employment and working contexts influenced responses to identity statistically significant distinctions. **Chapters eight and nine** explore the subsequent findings from the in-depth interviews, with chapter eight focusing on the identified roles of mental health social work and how these vary across practice contexts, and chapter nine detailing the parallel discussion of contextual influences which exist beyond role but conspire to influence role, with similar consideration of the variation.

**Chapter ten** brings these findings together into an overall discussion of the position and role of social work in mental health contexts, exploring the variation within the findings and proposing a model for mental health social work that attempts to explain the variable aspects of the role, as well as those which remain constant across practice contexts. Drawing on this, a model for understanding mental health social work professional roles is proposed and explored. The chapter concludes with a consideration of the limitations of the research and the implications of the findings both in terms of future research and ongoing policy and practice.

Professional identity and professional role in social work are areas of increasing interest and increasingly apparent ambiguity (Webb, 2017). For mental health social work in particular, straddling the divide between health and social care services in a relatively unique way, this ambiguity has led to increased focus (Allen et al, 2016; Clifton and Thorley, 2014) but with minimal impact (Tucker and Webber, 2021) with a failure to fully explore how context influences identity and role enactment. This thesis aims to offer insights to help address that gap, positioning an understanding of mental health social work directly within its practice context(s). The intention in doing so is to distinguish the aspects of the role which are contextually specific from those aspects which apply universally to help develop a more comprehensive and robust definition of mental health social work suitable for all settings.

# Chapter 1 - Setting the scene: Mental health social work in a historical context

To understand the position of social work within mental health services in a contemporary context, it is important to first understand the historical context within which the mental health social work role has evolved. The importance of understanding the past as a key component of informing the present and predicting the future has been a recurring theme in considerations of social work history (McGregor, 2015; Queen, 1922) and social work and mental health care saw a parallel development throughout their respective histories, with changing attitudes toward mental health care in the late nineteenth and early twentieth century being mirrored by the emergence of a new social work profession. In the context of a profession so responsive to its environment and whose existence arises from and is continually shaped by prevailing economic, social and political influences (Harris, 2008; Gregory and Holloway, 2005) shifts in political, medical and social priorities throughout its past will inevitably have had their influence on social work's present. Considering the present position of mental health social work in isolation detracts from a fuller understanding of the profession and the ways in which it has been shaped by its own history.

Establishing this history is by no means a simple task, however. Existing historical accounts primarily focus on either a generic history of social work (see, for example, Bamford, 2015; Payne, 2005; Younghusband; 1981; Seed, 1973; Woodroofe, 1962) or a generic history of mental health services (see, for example, Glasby and Tew, 2015; Rogers and Pilgrim, 2001; Freeman, 1998; Jones, 1960) and comprehensive accounts which cross between the two perspectives are limited. The outcome is a social work history dominated by an emphasis on work with children and families, and an understanding shaped by a focus on child abuse (Dickens, 2011) and a mental health history told from a legislative and medical standpoint, where the social work perspective is marginalised.

Where the two elements to this history are combined, the focus has been on the easily delineated professional role of the Psychiatric Social Worker (PSW) (see, for example, Broad, 2021; Henning, 2018; Timms, 1964), disregarding the pre-existing arrangement and parallel

development of local authority provisions which have invariably influenced the current composition of the mental health social worker (Burnham, 2011). This focus allows for a full understanding of this elite branch of social work practice, but overall only a partial and blinkered understanding of mental health social work as a whole (Burnham, 2011). Lorenz (2007, p. 599) suggests that this restrictive perspective is detrimental to a nuanced understanding of mental health social work identity, urging that social workers should reject simplistic narratives of social work in order to "listen to the incredible diversity that characterises our profession and face up to the discrepancies, the discontinuities and the disharmony which are also part of this history."

It is beyond the scope of this thesis to explore all the "bewildering diversity of forms of practice" (Lorenz, 2007, p. 610) that have personified throughout social work history, but equally it would be disingenuous to accept and promote the simplistic understanding of social work as an obvious response to a self-evident need (Harris, 2008). As Oakeshott (1983, cited in Smith, 1996) argues, although a historical attitude to the past involves an awareness that all facets of the evidence play a contributory role in determining the present, the role of a historian is to explicitly acknowledge their specific focus in constructing a history. Indeed, drawing in all aspects of social work history produces an account which is inclusive but also impenetrable.

This chapter aims to address such incomprehensibility. To assist in the specific understanding of mental health social work requires not a disregard of other aspects of social work history, but a narrowing of focus to the pertinent areas to avoid an account which becomes unwieldy through density. The intention therefore is to present a narrative which co-positions social work and mental health care in order to aid an understanding of how the historical progression of each has impacted on the other and how, in turn, this situated understanding can help to inform and interpret the contemporary position. Fully understanding the historical context of practice provides the foundation against which the current role of mental health social work can be positioned and contextually interpreted. In brief, understanding how the current position arose will aid better understanding of what the current position is.

Beginning therefore from the emergence of social work during the late nineteenth century, the chapter will explore key developments in practice and policy for both social work and mental health, exploring where these interact and also how changes within one context impact upon the other. It will consider the appropriateness of the 'standard' narrative which roots social work history in the UK firmly in the work of the Charity Organisation Society and the Settlement Movement and compare this with corresponding mental health provision in local authority contexts. The impact of changing perspectives in the twentieth century linked to less punitive approaches to distress, combined with the emergence of the social work professional will be explored through the lens of the Psychiatric Social Worker and in the context of the Mental Welfare Acts. Following this, the chapter will explore the increasing division between health and social care, with the introduction of a National Health Service which excluded social care from its remit, and the subsequent homogenisation of social work as a distinct entity, and how this impacted for social work roles which by necessity crossed that health-social care boundary. The increasingly complex policy and legislative framework of the late twentieth and early twenty-first centuries, including the impact of increased devolution of the UK nations, will be discussed, with a consideration for how political ideologies have influenced and impacted on how mental health social work is delivered. Finally, the chapter will consider the current position of mental health social work in England and Wales and what this context implies for the future of the profession.

## 1.1 Emerging social work: England in the nineteenth century

The earliest provision of social work is well-documented as being inextricably linked to the emergence of the Charity Organisation Society, arising in response to the apparency of need within a newly industrialised society (Queen, 1922). This reflected an adjustment to the standard approach of philanthropy in the context of a much larger scale of distress (Seed, 1973). The Poor Law reforms of 1834 had moved the legislative framework away from earlier principles of locally provided outdoor relief, seen as unwieldy and unsuitable for a larger urban population (Harris, 2008), to a more centralised and punitive institutional system of workhouses, designed in part to discourage unrestricted use of state support. This reflected the wider state approach during this period, where intervention for welfare,

specifically in the fields of labour rights and education, was present but grudging (Woodroofe, 1962). Promotion of individualism and personal responsibility was paramount; reflecting both the need and the reluctance of the state to intervene in and regulate public life in the context of increasing industrialisation and urbanisation (Cree and Myers, 2008).

The charitable interventions of the Victorian period arose arguably not from an overwhelming sense of injustice at the inequalities of society, but rather as a response from the middle classes to the increasing anxieties posed by the emergence of a disordered and therefore threatening working class (Payne, 2005). Webb (2007a; 2007b) argues that intervention was driven by a desire to morally reorder the lower classes, using a relationship building approach in order to regulate from without, with the relationship itself viewed as an opportunity to offer moral guidance (Gregory and Holloway, 2005).

Intervention in this era arose from two key channels; the CharityOrganisation Society, with an emphasis on addressing the individual impacts of poverty, and the Settlement Movement, which focused on the collective needs of working poor communities (Scheuer, 1985). Ostensibly, these approaches were markedly distinct from one another, with the former advocating moral judgement of individual capacity for self-betterment, based on a 'scientific' judgement and classification of need and relief (Horsley et al, 2020) and the latter promoting a programme of social reform aimed at bridging the gap between social classes for the betterment of working families (Ginn, 2020). However, the differences between them could be argued to have been more ideological than actual. Hunter (1902), writing contemporaneously at the height of work of these respective movements, argued that without a sense of engrained rivalry, there was substantial common opportunity and intent. Although framed in that discussion in a positive light, this is perhaps not surprising; the moral focus of the Charity Organisation Society was mirrored in the paternalistic approach of moral improvement rooted in the education of the working poor which characterised the Settlement Movement (Ginn, 2020). Similarly, the scientific approach to casework, with an emphasis on interrogation and classification (Horsley et al, 2020) which informed the Charity Organisation Society approach could be argued as being similar to the scientific survey and surveillance of working poor populations which underpinned the settlement

work (Köngeter, 2020). The overall aims might have differed, but the methods adopted bore similarities.

Although the Charity Organisation Society and the Settlement Movement have been established as influential in development of modern social work as a whole (Horsley et al, 2020; Ginn, 2020; Köngeter, 2020) it is not the intention here to explore these in depth. The specific foci of these respective approaches had a more minimal impact on the development of mental health social work specifically, by comparison to the profession more generally. In the context of the Settlement Movement, the target of their intervention was the working poor, those employed within the industrial framework but experiencing poverty regardless (Hunter, 1902), a category more likely to exclude than include those experiencing mental illness. The Charity Organisation Society shared the legislative perspective of lesser eligibility, derived from the deserving poor principles of the seventeenth century (Bamford, 2015) dovetailing their work in partnership with the Poor Law Relieving Officers. Details of applicants were passed between the two as deemed appropriate (Harris, 2008), and they operated under the premise that "we aim at decreasing, not suffering but sin" (Barnett, 1886, cited in Stedman Jones, 2013, p. 271).

This co-operative approach to intervention has particular significance in the context of mental health social work. The criteria for assistance from the Charity Organisation Society was a capability for moral betterment, as assessed using their casework approach, and a move toward occupying a position as a contributing member of society. Similarly to the Settlement Movement, this positioned them to work most naturally with those who were younger, more able to potentially work or experiencing short-term hardships. Those deemed to be chronically ill, including those with mental illnesses, were redirected to the Poor Law Relieving Officers (Burnham, 2012), with the result that the chronically mentally unwell needed to be housed in workhouses which had not been designed for this purpose (McCrae and Nolan, 2016; Freeman, 1998) and where the systems could not easily accommodate them (Rogers and Pilgrim, 2001). With the emphasis in the 1890 Lunacy Act on a response to pauper lunatics (Jones, 1960), with Relieving Officers central to the process of their detention to an asylum (Butler, 1993), this positioned those deemed mentally unwell to receive the majority of any intervention from these state appointed officials.

It is worth noting at this point the distinction between housing in the workhouse and detention in the asylum. Arising from principles of philanthropy and utilitarianism (McCrae and Nolan, 2016), legislative reform in 1808 and 1845 first allowed and then compelled county councils to provide and run county asylums for paupers (Brimblecombe, 2006), providing an option for care to those unable to meet the costs of private hospitals and madhouses (Bartlett, 1998). While the legal expectation was for the mentally unwell to be housed within the asylum system, in reality this was not always the case. By the late nineteenth century, staffing levels remained low in relation to patient numbers (Brimblecombe, 2006) with overcrowding (Chu et al, 2018) and high rates of staff turnover (Brimblecombe, 2006) an ongoing challenge. The workhouse therefore was also integral to mental health institutional care (Bartlett, 1998). Although less well known than their asylum counterparts, the two systems of state worked in partnership. Asylum records evidence patterns of patient transfer between the asylums and workhouses (Chu et al, 2018; Bartlett, 1998). Indeed, in 1844, less than one in four of the mentally unwell were housed in an asylum, with more than half in the cheaper and more readily available workhouse setting (McCrae and Nolan, 2016). Even by the end of the century, approximately one in four of those deemed mentally unwell remained housed in workhouses (Bartlett, 1998), while within the first quarter of the twentieth century, admission rates to the workhouse rose to equal that of the smaller asylums (Cowan, 2021). The workhouse was an adjunct, rather than an addendum to the asylum system; in the view of the Lunacy Commissioners, those with the lowest prospects of recovery were more suitably housed within the workhouse than under the therapeutic auspices of the asylum (Bartlett, 1998), although this optimism in the curative potential of the latter faded as the century progressed. However, whether detained to the asylum or committed to the workhouse, the mentally unwell portion of society remained under the purview of the Relieving Officers.

Critical to this understanding is the prominence of the legislative officers rather than the charitable practitioners in the provision of care to this group. Timms (1964, p. 2) suggests that the Poor Law service was “unaffected by the principles of social work”, operating instead within a punitive system intended to deter as much as to relieve (Woodroofe, 1962). However, such a view is arguably overly simplistic; while it was expected that Relieving

Officers would apply the rules harshly, with a gentler approach taken by the visiting charitable workers, this was not universally enacted. Burnham (2012), for example, illustrated examples of Relieving Officers in rural areas where charitable endeavours were less common, maintaining a more supportive and less punitive role through the provision of out-relief. Instead, rather, the challenges of balancing the harsh demands of the Poor Law administration with the realities of the individuals that Relieving Officers worked with presented, in at least some contexts, an early example of the debate between care and control which would later come to dominate social work discourses (Coppock and Dunn, 2010).

## 1.2 A more socialistic outlook: Shifting perspectives in the early twentieth century

By the turn of the twentieth century attitudes toward poverty and distress had started to move away from the punitive, moralistic approaches of the Victorian era toward a more progressive, welfare-orientated perspective (Bamford, 2015). Informed in part by the pioneering studies by Booth (1903) and Rowntree (1901) - which highlighted the nature of poverty as something eclipsing individual responsibility – but also by the growth of trade unionism and reformist societies such as the Fabians and Poplar Guardians and by heightened awareness of the social emphasis on community promoted by the Settlement Movement, the harsh administrations of the Poor Law came under increasing criticism (Bamford, 2015; Payne, 2005). The first legislative changes to reduce its influence by increasing labour rights and introducing state systems to insure around unemployment, health and old age were introduced.

Parallel to this, the emerging Guilds of Help – locally organised charitable organisations who worked in close partnership with the Poor Law Unions and Local Authorities and established a role for social work within health settings – were popular with volunteers and spread prolifically, particularly in the north of England. By contrast, the Charity Organisation Society saw its influence decline, and those willing to volunteer within it declined in number from the 1890s onwards (Burnham, 2011), although it remained one of the largest providers of family welfare work well into the twentieth century (Todd, 2014). The landscape of social welfare was changing, and these changes were illustrated perhaps most vividly in the schism

which occurred within the 1905 Royal Commission on the Poor Laws. Unable to reach a consensus, the Commission issued two reports. The first proposed moderate reform to the existing system including a change of name, provision of unemployment insurance and the separation of provisions for the mentally ill and for children. The second, more radical approach, proposed a move from relief to prevention, with a state responsibility to produce a system which safeguarded against hardship (Bamford, 2015).

Specifically in the provision of mental health social work, this period reflects a shift from the emphasis on containment and control towards one of care and support. The role of the Relieving Officers was adjusted and expanded; a relaxation of harsh rules which enabled a more productive relationship to be formed between those seeking assistance and those providing it (Burnham, 2011), reflecting an ongoing emphasis on the significance of relationship building within both social work in general and in mental health social work specifically. The rise of the mental hygiene movement, with its emphasis on the move away from the asylum and appropriate aftercare (Henning, 2018) also predicated a specialist Relieving Officer role specifically to work with lunatics, not only around detention but also to advise and help in facilitating a return to the community (Burnham, 2011).

The experiences of the First World War threw into sharp relief the experience of mental distress not as the expression of a personal failing, but as a response to environmental stressors that impacted regardless of class, status or wealth (Sheldon and MacDonald, 2009; Rogers and Pilgrim, 2001) and rendered the idea of worthiness as a requirement for aid obsolete (Burt, 2008). The increasing need arising from a veteran population struggling to manage the psychological impact of warfare and the woeful inadequacy of the existing social work structures to provide effective support in those areas being increasingly deemed important, such as hospital aftercare (Henning, 2018) necessitated a move toward change within the profession. With the social work workforce still comprised of a broad range of volunteers, informally trained workers and ‘experts by experience’ (Burt, 2008), there was a clear need for further development within the profession to meet the increasingly complex demands of working with those in need.

## 1.3 The rise of professionalism: The psychiatric social worker in the interwar years

Writing contemporaneously, Queen (1922, p. 24) suggests that "social work is not yet a profession but is in the process of becoming one". Central to his arguments in support of this position was the practice-based nature of social work training and the lack of a formal educational structure informed by a theoretical body of knowledge; a position acknowledged by modern social work historians who position the 1920s as the era in which social work attempted to move away from its philanthropic roots to adopt a more professional platform (Henning, 2018). It has previously been suggested that the moral perspective adopted by social work during its inception arose in part from the lack of a formal body of knowledge upon which to base interventions (Younghusband, 1981), with the Charity Organisation Society adopting a scientific approach rather than working from a scientific foundation (Horsley et al, 2020). Formal training had already begun to emerge through training established for the hospital almoners (Bamford, 2015), although the broad scope of roles covered by the social work title made consensus around training a challenging thing to achieve (Burnham, 2012). The progression for this training emerged within mental health in the form of the Psychiatric Social Worker (PSW).

Interest in psychotherapeutic approaches influenced by Freudian perspectives gained increasing currency and legitimacy in the aftermath of the First World War. Provision for mental health saw a shift from an emphasis on incarceration within the asylum to an outpatient-based model of intervention (Rogers and Pilgrim, 2001). However, existing service provision was woefully insufficient to meet the needs being presented in these settings, with a recognition that services needed to be developed (Henning, 2018; Jones, 1960) and the expanding and diverse workforce needed to be upskilled (Burnham, 2012). Funding was secured for a group of English social workers to undertake psychiatric social work training in America in the late 1920s, with the first formal training for psychiatric social workers in England subsequently established at the London School of Economics in 1929 (Burt, 2008).

These new 'professional' social workers arguably heralded a new direction for mental health social work, positioning it for the first time directly within the mental hospital setting.

Timms (1964) suggested that they operated as a bridge between the hospital and the home both as a physical and as a social space, with a specific emphasis on work with the relatives of those deemed to be mentally ill. Like the Relieving Officers, their role primarily book-ended the hospital admission process, with their involvement focused on admission and subsequent social reintegration. However, unlike the Relieving Officers, whose role in admission was primarily legislative and administrative, the PSWs, informed as they were by psychological approaches, focused on building social, contextual histories in a manner reminiscent of modern social work practice (Burt, 2008).

The PSW was arguably a prestigious role, with criteria for enrolment in the training both demanding and exclusive (Henning, 2018). This in turn represented those who qualified as an elite branch of practitioners with a specialist knowledge of relationship work (Burt, 2008). However, the role did encounter two significant challenges. The first was one of practicality and positioning; although the role was lauded and promoted by the Board of Control (Jones, 1960), there was little evidence of any centralised planning or role positioning for these new professionals within the existing arrangements for mental health support. The role therefore became primarily locally defined, with both its scope and effectiveness influenced by local priorities and working relationships (Timms, 1964). This lack of a wider vision and coordination impacted beyond the PSW, however, and is reflective of wider issues in the organisation and provision of services, as seen from a pre-war hospital survey which identified existing services as "inadequate, uncoordinated and often seriously obsolete" (Freeman, 1998, p. 228).

The second challenge arose in terms of an ideological criticism of the PSWs' theoretical roots. The search for legitimacy had encouraged social work as a whole to seek a rigorous academic footing upon which to base its claims to knowledge. In the absence of a social work specific evidence base, it had instead drawn ideas from psychiatry, psychology and sociology, leading to subsequent accusations that social work had been swamped under a 'psychiatric deluge' and become divorced from its social roots and any consideration of the wider social influences identified in the previous decades (Field, 1980). Henning (2018) draws on representations of the professional training for psychiatric social workers which emphasise the academic rigour of the courses, while downplaying the practice-based

practical element of the training, despite this playing a substantial role in the award of the final qualification. She positions this adoption of external academic frameworks as primarily driven by the quest for professional acknowledgement, underpinned by a search for credibility rather than competence, although Lees (1971, p. 377) disputes this interpretation as being reflective of a simplistic "practical attitude to the past", which ignores the complexity of a historical situation in favour of producing a simple explanation for a current position. Rather, he clearly demonstrates an ongoing preoccupation with social reform and change throughout the 1920s and 30s, which runs in partnership with the growing interest in psychodynamically informed approaches.

Discussions of mental health social work in this period are frequently dominated by a focus on the rise of psychiatric social work; however, the interwar years also saw a significant shift in the position of Relieving Officers and local authorities in the delivery of services for those deemed mentally unwell. Legislative changes had substantial impact on the focus and delivery of services. The Local Government Act 1929 took a further step in disassembling the Poor Law by abolishing the Board of Guardians and moving the associated responsibilities into a local authority remit (Bamford, 2015; Jones; 1960). Correspondingly, in the mental health arena, the report of the Macmillan Commission (Royal Commission on Lunacy and Mental Disorder, 1926) resulted in the passing of the Mental Treatment Act 1930, which prioritised voluntary treatment and a much broader scope of local authority provided outpatient care (Glasby and Tew, 2015). Significantly, in the context of the growing unpopularity of the Poor Law legacy, the Act also redefined Relieving Officers as Duly Authorised Officers but retained their role in the involuntary admission to mental hospitals (Burt, 2008).

The impact of these changes on the Relieving Officer workforce is somewhat disputed. On one hand, it has been suggested that Relieving Officers remained responsible for the much-loathed means test for assistance prevalent in the 1930s (Harris, 2008) and struggled to engage with more progressive approaches to social problems than had previously been their remit (Burt, 2008). Burnham (2012) however suggests a more complex picture in the relationship between Relieving Officers, the socially progressive mindset and the individualistic legislative approach, with both some individual practitioners and local

authorities adopting the socially progressive approaches in direct contradiction of guidance from central government. The Mental Treatment Act 1930 itself provoked similar conflict. It returned to a more medicalised perspective of mental health than its legalistic predecessor and arguably epitomised the same core debate between care and control that continues to challenge the profession to this day (Rogers and Pilgrim, 2001). Critically, here, we see the same debates which currently form and shape social work practice in mental health contexts played out over the history of the profession.

## 1.4 An era of reimagining: From Beveridge to Seebohm

The major reforms of the welfare state took the final step in divorcing social work from its roots within the provisions of the Poor Law. The National Assistance Act 1948 saw the final functions of the Poor Law rebranded and placed under the auspices of local authority provision (Bamford, 2015), with the Relieving Officer role now universally supplanted by the Duly Authorised Officer (Burt, 2008). However, the provision for mental health remained to an extent directionless. Political interest in mental health was low across the political spectrum and roles with state-led mental health social work required neither knowledge (Freeman, 1998), nor training (Burnham, 2012). The psychodynamic approaches favoured in previous decades translated poorly into the state-led setting (Harris, 2008) and remained the purview of the PSWs, who played only a minor role in the local authority setting. The result was the development of mental health social work on a primarily pragmatic basis, side-lined by the wider welfare reforms and uninformed by either theory or policy (Freeman, 1998), within the new Mental Welfare departments staffed by the same practitioners, now referred to as Mental Welfare Officers, who had previously operated as Relieving Officers and who, without more explicit guidance, continued to practice in the same restrictive ways (Burnham, 2012; Burnham, 2011).

The coming decades were to see an increasing move toward community care and away from the institutional focus of previous mental health legislation. The Ministry of Health Annual Report in 1955 was the first specific reference for the need to move toward community care, while the Percy Report (Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, 1957), which was to lead in turn to the Mental Health Act,

1959, recommended a repeal of all existing legislation in favour of a legal code aimed to minimise admission (Freeman, 1998). Instead, it proposed a wide-ranging scheme of local authority community services (Glasby and Tew, 2015), reflecting a change in public and professional perspectives on mental health toward something less punitive (Welshman, 1999)

The rationale for this approach in somewhat unclear; there is little evidence of a governmental commitment to deinstitutionalisation. The Mental Health Act 1959, although adopting a medical rather than a judicial approach to decision making (Peck and Parker, 1998) failed to provide for community-based services to complement those of the hospitals (Freeman, 1999), although it did reinforce expectations of local authority provided aftercare. It has been suggested that the development of effective psychotropic medication during the 1950's opened the possibility for a more community led approach to severe mental illness (Drake et al, 2003; Freeman, 1998); however, Rogers and Pilgrim (2001) dispute this causal link, highlighting that the move toward deinstitutionalisation both predates the introduction of these medications, as well as encapsulating a broader range of people than those affected by them. They suggest instead that the rationale may be somewhat more pragmatic and financially based, although the suggestion that community care provides a more cost-effective approach than institutionalisation is arguably equally false (Thornicroft and Tansella, 2003). Scull (2021), writing in an American context, goes further in debunking the link with medication effectiveness, suggesting that while motivations for deinstitutionalisation might not have been political, they were ideological, bringing together oppositions to incarceration on the left and to public service provision on the right. While the context differs, in that the provision of public healthcare in the UK setting should in principle mitigate against community care becoming "an Orwellian euphemism masking a nightmare" (Scull, 2021, p. 79), rationales for deinstitutionalisation and community provision remain elusive and approaches in context vague.

Indeed, the Mental Health Act 1959 took a somewhat laissez-faire approach to community care and aftercare; local authorities were invited but neither compelled nor funded to implement broadscale community programmes (Glasby and Tew, 2015; Welshman, 1999), while the specialist PSW approach was disregarded, leaving their role across the hospital

and community boundary unclear, uncoordinated and to an extent underappreciated (Timms, 1964). Mental health work within local authority settings became dominated by removal to hospital rather than effective intervention, where medical opinion held significant influence (Burnham, 2012; Rogers and Pilgrim, 2001). As a result, mental health social work into the 1960s represented an area of work undertaken by largely unqualified local authority staff (Burnham, 2011) in settings which were under-resourced to provide any effective community-based care (Freeman, 1999).

Policy and action in this period failed to coalesce to provide any direction for mental health social work. The 1962 Hospital Plan for England and Wales (House of Commons, 1962) was representative of a wider political narrative built around reducing the segregation and separation offered by a widescale institutional approach (Glasby and Tew, 2015) but offered little in the way of a framework for how this might be achieved (Rogers and Pilgrim, 2001). In fact, the 1960s instead saw large-scale investment in hospital settings despite the claims that their ongoing provision was to be limited (Freeman, 1998).

Compounding this uncertainty was an increasing move within the profession toward a more generic approach to training, aimed at providing an overall consensus of approach within a range of specialist occupations (Jones, 2014; Burnham, 2011), with the result that the first generic training course for social work was established at LSE in 1954. The fragmentation of social work in the context of increasing numbers of social work professions contrasting with the shared sense of identity arising from joint training led to calls to create one unified approach to social work (Harris, 2008) from both within and without the profession; including formal reviews into the effectiveness of different aspects of social work provision (Dickens, 2011). The formation of the Standing Conference of Organisations on Social Work in 1963, which included both the Society of Mental Welfare Officers and the Association of Psychiatric Social Workers, reflected the inherent debate in both retaining differing priorities and standardising the professional approach to social work across all of its endeavours (Dickens, 2011).

## 1.5 Constant reinvention: The unification and bureaucratisation of social work

Local authority social work at this time was reflective of the fragmentation of the profession as a whole. Social services were provided by children's, welfare and health departments (although these latter were combined in around 200 local authorities) and responsibility for these departments was split across two governmental departments (Dickens, 2011). The Seebohm Report (Seebohm Committee, 1968) operated with the specific remit of identifying where provision of personal social services might be made more effective (Harris, 2008). It identified issues with inaccessible and inadequate provision, underpinned by a lack of resources, knowledge and inter-departmental cooperation (Dickens, 2011) and instead called for more comprehensive and universal provision which enabled a holistic approach to complex circumstances (Harris, 2008). Its recommendations were largely hailed as a positive step toward a more effective and professional approach to social work, despite some concerns from the specialised branches within the profession, including the PSWs. Notwithstanding these concerns, however, the recommendations were adopted under the Local Authority and Social Services Act 1970, placing social work for the first time in its history in a centralised position of power and responsibility (Bamford, 2015; Harris, 2008).

The advent of generic social work provision saw the end of the PSW; specialist PSW training was ceased following the introduction of the generic Diploma in Social Work in 1970 (Henning, 2018), with the Association of Psychiatric Social Workers dissolving in 1971 to be incorporated within the broader scope of the newly formed British Association of Social Workers (Goodwin, 1990). Local authority mental health departments and PSWs were subsumed into the newly formed Social Services Departments, while mental health hospital provision remained under the purview of the NHS, with the ironic result that the administrative changes which were an inevitable consequence of unification served to divorce the practices of psychiatry and mental health social work by the mid-1970s (Goodwin, 1990). Although Mental Welfare Officers retained their legislative responsibilities in relation to detention, unification of social work had been achieved in a manner which divorced social work from mental health. The goal of professionally common training had been achieved, but at the cost of developing and maintaining both professional skills and cross-disciplinary relationships which prove critical to mental health care (Webber, 2011). Closer working relationships developed between psychiatry and psychiatric nursing,

to the exclusion of social work (Henning, 2018), while relationships between social work and psychiatry became divided and fractious (Freeman, 1999).

The success of the new Social Services Departments is questionable; their focus, rather than being generic and holistic, was primarily children and families focused. Historical specialisms influenced practice across the different areas of need, with the result that practice was highly variable (Burnham, 2012) and approaches, rather than being informed by varying aspects of specialist knowledge, were largely influenced by the legislative frameworks under which social workers operated. The Seebohm reforms had drawn an inextricable link between the local authority and the social worker, intertwining the professional and the agency to produce a form of "bureau-professionalism" (Harris, 2008, p. 671). As a result, by the 1970s, social work had become defined by the tasks and expectations of the local authority rather than existing within its own right (Gregory and Holloway, 2005).

This was to prove a substantial challenge for the profession in the coming decades, as the economic challenges of the 1970s undermined public faith in the effectiveness of the welfare state (Gregory and Holloway, 2005). *Better Services for the Mentally Ill* (Department of Health and Social Security, 1975), reflected the first major shift in mental health policy since the County Asylums Act 1808 (Freeman, 1998) in outlining a comprehensive framework to enable community provision to eclipse hospital provision in mental health care with a clear plan for health and local authority integration (Glasby and Tew, 2015). However, the policy also acknowledged that the economic restraints of the time precluded the implementation of this (Welshman, 1999). Policy rhetoric and economic reality positioned the state to fail in its aspirations and social workers, now established as agents of the state, became seen as complicit in this failure.

The reduction during the 1980s of state provided services reflected a rise in new right thinking reminiscent of the Victorian approach to welfare, with an emphasis on restraining expenditure and increasing accountability (Brodie et al, 2008). Three key themes underpinned discussions around welfare in this period: excessive state involvement, the cost of welfare and over-dependency on welfare (Harris, 2008). The growth of a market-

driven and neoliberal perspective, viewing those who use services as consumers, clashed with social work's professional ethic and rights-based approach resulting in a hostile environment (Jones, 2014). Indeed, the recommendations of the Barclay Report (Barclay Committee, 1982) posited that social work should focus on a community-based approach, positioning the community as the most effective source of help, a theme which would be reflected throughout the coming decades. Although laudable in principle, reflecting a growing social inclusion narrative with a potential to strengthen communities and embed people in these community contexts, which is especially critical in the context of mental health (Huxley and Thornicroft, 2003), it is arguable that the temporal position of the report reflects an attempt to reimagine social work in a light that would reflect New Right ideals (Jones 2014; Harris, 2008) rather than try to challenge neoliberal approaches that were positioned as both progressive and empowering (Brodie et al, 2008).

This positioning of social work to minimise state intervention was similarly reflected in the legislation and policy of the time; the Mental Health Act 1983 reflected none of the community care plans outlined in Better Services for the Mentally Ill, instead emphasising a more legalistic approach, including specific safeguards around and criteria for detention which positioned within the law a distinct shift toward service user rights, although the extent and effectiveness has been questioned over subsequent decades (Bartlett, 2011). Reflecting this, for the first time specific requirements in the administration of the Approved Social Worker role (which had replaced the Mental Welfare Officer) were introduced (Peck and Parker, 1998), arguably both standardising and proceduralising the social work role within hospital detention. A similar approach was evident in responses to the Short Report (House of Commons, 1985) which cautioned the need for careful management of the move from institutional to community services to minimise demand. While inpatient numbers fell drastically during the decade, minimal government involvement meant that this occurred without the essential corresponding development of long term, robust community services (Peck and Parker, 1998). Alongside this, the Griffiths Report (Griffiths, 1988), which ultimately informed the NHS and Community Care Act 1990 promoted the move toward a mixed-economy of care using a purchaser-provider model, clearly intended to minimise the state role in intervention and maximise its role in administration (Brodie et al, 2008).

The NHS and Community Care Act 1990 and the Children Act 1989 saw social services departments managing substantially differing legal responsibilities in relation to children and adults, placing the ideal of the holistic, unified social services under increasing pressure. The impact of this strained attempt at unification on mental health social work in particular was profound. The integration of social services had done much to disintegrate mental health provision, with social workers within local authorities engaged in a struggle for resources prioritised toward children and residential support (Freeman, 1998). Community mental health provision had also developed in isolation from social work, with Community Mental Health teams emerging from the 1970s onwards. These were initiated and led by psychiatrists and challenged in their implementation by service structures which drew upon policy from multiple government departments and failed to enable a truly integrated approach (Bogg, 2008; Peck and Parker, 1998).

The neoliberal leanings of the 1980s retained a degree of prominence within mental health and social care policy (Pilgrim, 2012). The market-driven approach and managerial perspective were foregrounded throughout the 1990s (Harris, 2008), informed in part by a rising focus on risk prediction and management and a technicalisation of roles (Gregory and Holloway, 2005). Arguably for social work in mental health, this introduced the era of bureaucracy; within adult social care, models of care management, predicated on a business and management culture were adopted as the norm (Gregory and Holloway, 2005), while in mental health services, the Care Programme Approach sought to standardise and rationalise mental health provision (NHS England, 2021).

Critical to and underpinning these changes within both social work and mental health was a reactionary preoccupation with the management and reduction of risk. The Care Programme Approach had arisen from the recommendations of the Spokes report (Department of Health and Social Security, 1988) into improving the quality of care in the community for those deemed mentally unwell, but the impetus to produce the report had been the death of Isabel Schwarz at the hands of her previous client (Peck and Parker, 1998). Further implementation of the policy was driven by other deaths including those of Jonathan Zito and Ben Silcock (Peck and Parker, 1998) but this was targeted at managers rather than clinical professionals and attempts to engage professionals with this approach

to practice on an evidentiary basis were limited. This was followed at the turn of the century by the redivision of social services into adults and children's provision, again not as part of a wider strategy but in response to the tragic death of Victoria Climbie (Dickens, 2011). This reactionary approach to policy making generated a challenging environment for the effective practice of mental health social work. Brown (2006) suggests that risk driven approaches couched in the language of need results in ineffective and confused policies which aim to achieve two competing aims and manage to achieve neither. Indeed, Pilgrim (2012) argues that mental health work is not aimed at addressing the needs of the individual, but rather the needs of society and the economy in managing and controlling this discordant element of the population. This produces a practice environment ill-suited to the mental health social worker, driven by a social justice and person-centred approach which fits poorly with a risk-emphasised approach.

## 1.6 Planning for the future or reacting to the past: social work into the twenty first century

In contrast to the preceding hundred years, social work and mental health provision in the twenty first century have been subject to a range of detailed, albeit frequently contradictory policy directives, some critical aspects of which are detailed in Table 1.1. Arguably, this partly arises from the emphasis on surveillance and regulation adopted by the New Labour government of the late 1990s, which prioritised more central oversight and control of local authority activity through the use of detailed National Service Frameworks and a strong culture of outcomes reporting and regulatory oversight (Harris, 2008). Such regulatory intrusion erodes innovative social work practice and encourages disengagement with policy rhetoric (Preston-Shoot, 2001); however, it also enables the increasing standardisation of work previously undertaken with professional autonomy and informed by tacit knowledge and practice experience (Webber, 2013).

| *Legislative Addition* | *Date* | *Format* | *Country* | *Impact* |
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| County Asylums Act | 1808 | Act of Parliament | England and Wales | Allowed local authorities to build and operate asylums to meet the needs of those unable to pay for mental health medical care, with the intention of ensuring those who were mentally unwell were housed in hospitals. The elective nature resulted in very few asylums being built. |
| Lunacy Act/County Asylums Act | 1845 | Act of Parliament | England and Wales | Concurrent legislation which established both the Lunacy Commission to oversee mental health provision and legislation and changed the county provision of asylums from optional to mandatory. |
| Royal Commission on the Poor Laws | 1905 | Report | England and Wales | Report into reforms of the Poor Laws following increasing public dissatisfaction. It failed to reach consensus and issued two reports: one proposing moderate reform and the other proposing a full overhaul of the system, with a focus on prevention. The corresponding change in work of the Relieving Officers saw a less punitive and more cooperative relationship in working with those deemed mentally unwell. |

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| Macmillan Commission | 1926 | Report | England and Wales | Report positioning mental health as a public health issue which argued for a move away from detention and toward prevention. Informed development of the Mental Treatment Act, 1930. |
| Local Government Act | 1929 | Act of Parliament | England and Wales | Abolished the Board of Guardians, moving the associated responsibilities under local authority remit, thus positioning Relieving Officers as local authority agents. |
| Mental Treatment Act | 1930 | Act of Parliament | England and Wales | Legislation arising from the Macmillan Commission report which emphasised a medical interpretation of mental health but prioritised voluntary treatment and local authority care. The Act also reframed Relieving Officers as Duly Appointed Officers, severing the link to the Poor Laws but retaining their role in mental health hospital detention. |
| National Assistance Act | 1948 | Act of Parliament | England and Wales | Fully abolished the Poor Laws, bringing all outstanding provisions under the remit of local authorities, bringing mental health care fully into the state led arena. Mental |

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| | | | | Welfare departments were established in local authorities, staffed by Mental Welfare Officers. |
| Ministry of Health Annual Report | 1955 | Report | England and Wales | Highlighted the need for community-based care for mental health |
| Percy Commission | 1957 | Report | England and Wales | Report proposing a repeal of all existing mental health legislation in favour of an approach which minimised admission and maximised local authority community provision. Informed development of the Mental Health Act, 1959. |
| Mental Health Act | 1959 | Act of Parliament | England and Wales | Working from a medical rather than a judicial perspective on mental health, this legislation reinforced expectations of local authority aftercare in cases of mental health detention but failed to legislate for community provision to match hospital interventions. No framework was made for the role of the Psychiatric Social Worker and local authority mental health work was subsequently dominated by hospital removals. |

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| A Hospital Plan for England and Wales | 1962 | Policy | England and Wales | Envisaged a reduction in the number of hospital beds needed for those mentally unwell, linked to ideas of mental health as curable, but failed to detail a plan for how this would be achieved. |
| Seebohm Committee | 1968 | Report | England and Wales | Report on the effectiveness of the personal social services, which recommended a unification of the different branches of social work to give comprehensive, universal and holistic provision. Enacted through the Local Authority and Social Services Act 1970. |
| Local Authority and Social Services Act | 1970 | Act of Parliament | England and Wales | Legislation requiring local authorities to run largescale, generic social work departments to work across categories of need. This effectively saw the clear division of social work and mental health provision; local authority mental health departments and psychiatric social workers were incorporated into the new social services departments (effectively ending psychiatric social work as a specialism), while mental health care remained within the remit of the NHS. |

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| Better Services for the Mentally Ill | 1975 | Policy | England and Wales | Outlined for the first time a comprehensive plan to integrate health and local authority provision to enable community support to take precedence over hospital care in mental health. However, implementation of the plan was precluded by the economic circumstances of the decade. |
| Barclay Committee | 1982 | Report | England and Wales | Report focusing on roles and tasks of social work, which emphasised the need for more community-based work. Recommendations of the report were not implemented. |
| Mental Health Act | 1983 | Act of Parliament | England and Wales | Legislation adopting a legalistic focus on mental health detention. Emphasis on procedure and criteria. Introduced the Approved Social Worker role, with specific administrative expectations, thereby standardising the social work role in mental health hospital detention. |
| Short Report | 1985 | Report | England and Wales | Governmental report from the Social Services Committee highlighting the under-provision of resources for meeting the needs in mental health. Contemporary accounts highlight |

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| | | | | that while expenditure in social care contexts was low, this did not hold true in health contexts (Goodwin, 1985), highlighting a disparity between mental health treatment and mental health care. |
| Griffiths Report | 1988 | Report | England and Wales | Report promoting a mixed economy of care, utilising a provider-purchaser model. Informed the NHS and Community Care Act 1990. |
| Spokes Report | 1988 | Report | England and Wales | Report on the quality of care for those with mental health needs, arising from concerns about risk. Led to the introduction of the Care Programme Approach. |
| NHS and Community Care Act | 1990 | Act of Parliament | England and Wales | Legislation setting out specific expectations for social care for adults, which differed to those offered for children. This compounded existing strain on mental health social work, which had already become divorced from mental health community provision with the rise of Community Mental Health teams through the NHS in the 1970s. Mental health social work became divided between the Care Management |

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| | | | | approach of adult social care and the Care Programme Approach of mental health services. |
| *Entries in the next section refer to policy and legislation enacted by the UK Government in Westminster following Welsh devolution. Unless noted otherwise they apply exclusively to England. Welsh specific legislation and policy will follow in the subsequent section.* | | | | |
| National Service Framework for Mental Health | 1999 | Policy | England | Prioritised workforce planning and professional skills mix in mental health services to ensure holistic provision of care. Identified social work as a specific mental health provision to be included within this. |
| Health Act | 1999 | Act of Parliament | England | Legislation enabling NHS trusts and local authorities to pool budgets, allowing for integrated mental health care. |
| Mental Capacity Act | 2005 | Act of Parliament | England and Wales | Legislation protecting the rights of vulnerable people in relation to decision-making. Frequently used in concurrence with mental health legislation, with an expectation that mental health social workers will exercise expertise in the enactment of the provisions. |

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| National Health Service Act | 2006 | Act of Parliament | England | Legislation consolidating existing provision for service integration enabling NHS trusts and local authorities to enter into formal partnership agreements under s.75, with mental health social work able to be positioned again within mental health services. |
| New Ways of Working in Mental Health | 2007 | Policy | England | Explicitly prioritised the development of individual skills and capabilities over dedicated professional roles. Complemented by reviews of the Care Programme Approach which specified universal skills and competencies across all mental health staff to work toward genericising the mental health workforce. |
| Mental Health Act | 2007 | Act of Parliament | England | Legislation which amended, but did not replace, the Mental Health Act 1983. Introduced a specific focus on social and psychological intervention, but also widened the Approved Social Worker role to the Approved Mental Health Professional, making this a generic role in line with the accompanying policy. |

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| New Horizons: Toward a shared vision for mental health | 2009 | Policy | England | Maintained the focus on generic mental health provision, detailing co-ordinated, cross-organisational care from a workforce which in all contexts held the requisite knowledge and skills. |
| No Health without Mental Health | 2011 | Policy | England | Emphasises the importance of a holistic perspective on mental health which includes social aspects and on interagency and cross-organisational working but maintains the emphasis on generic skill development across all mental health practitioners. |
| Care Act | 2014 | Act of Parliament | England | Legislation to consolidate local authority responsibilities towards those needing care and support and their carers. Establishes rights to assessment, emphasis on needs, carers rights and safeguarding obligations, and legally proposes an emphasis on prevention. Does not explicitly give duties to social workers, but substantially impacted on those social workers operating as agents of the local authority. |

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| NHS Five Year Forward View | 2014 | Policy | England | Promoted an emphasis on expert genericism and the meeting of needs through primary (health) provision rather than specialist secondary services. By implication, this minimises the role of mental health social work, which operated very minimally in primary care services. |
| Five Year Forward View for Mental Health | 2016 | Report | England | Report from the Mental Health Taskforce which argued for the need for a diverse professional workforce to bring a mix of skills and capabilities to mental health care. Elicited a positive governmental response which committed to the provision of a multidisciplinary workforce with specific acknowledgement of mental health social work. |
| NHS Long Term Plan | 2019 | Policy | England | Continued the emphasis on primary care provision through the IAPT intervention, with a specific focus on intervention over workforce diversity or skills. Proposed a corresponding remodelling for secondary mental health services, with a similar emphasis on interventions, although the singular social example within this was employment support. |

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| The Community Mental Health Framework for Adults and Older Adults | 2019 | Policy | England | Introduced a new community framework for mental health care to replace the Care Programme Approach. Included an emphasis on social interventions, but the focus is practical and generally outside the remit of mental health practitioners |
| Draft Mental Health Bill | 2022 | White Paper | England and Wales | Proposed revisions to the Mental Health Act 1983, which suggest a more rights-based focus than the existing legislation. |
| *Entries in the next section refer to policy and legislation enacted by the Welsh Assembly in Cardiff following Welsh devolution. Unless noted otherwise they apply exclusively to Wales.* | | | | |
| Government of Wales Act | 1998 | Act of Parliament | Wales | Created a devolved National Assembly for Wales, with some responsibility for a series of governmental functions including health and social care. The National Assembly had the power to pass secondary but not primary legislation. Existing relevant Acts of Parliament relating to social work and mental health remained in force in Wales. |

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| Adult Mental Health Services for Wales: Equity, Empowerment, Effectiveness, Efficiency | 2001 | Policy | Wales | Implemented a localised focus for mental health service provision aimed to design services meeting local need rather than an overall national approach. |
| Adult Mental Health Services: A National Service Framework for Wales | 2002 | Policy | Wales | Reaffirmed the local focus of service provision and confirmed the existing principles of equity, empowerment, effectiveness and efficiency. Demonstrated a move toward a more rights based, holistic approach to mental health provision and included, but did not define, a role for mental health social work. |
| Government of Wales Act | 2006 | Act of Parliament | Wales | Devolved primary law-making powers to the Welsh Government in health and social care, although some areas, specifically linked to the legal system, were retained by the UK government. |
| Mental Health (Wales) Measure | 2010 | Act of Senedd Cymru | Wales | Positioned the approach to mental health care as centred around principles of wellbeing, setting a legislative priority for mental health which encompassed in law a holistic consideration of the social circumstances of those in mental |

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| | | | | health need. Emphasised rights, recovery and quality of care over risk management, but appeared to have minimal impact on frontline social work or mental health practice across the English and Welsh contexts (Simpson et al, 2016). |
| Together for Mental Health | 2012 | Policy | Wales | Overall strategy to address mental health and wellbeing in Wales. Highlights a specific focus on social issues including stigma and inequality which suggest a particular space for mental health social work. |
| Social Services and Wellbeing (Wales) Act | 2014 | Act of Senedd Cymru | Wales | Introduced social care responsibilities in Wales to mirror those established in the Care Act 2014 for England, replacing the NHS and Community Care Act 1990 and associated legislation, with similar impacts for local authority associated mental health social workers. |
| Together for Mental Health Delivery Plan: 2019-22 | 2020 | Policy | Wales | Implementation plan for the existing mental health policy which includes a review of the composition and deployment of the mental health workforce, including mental health social work. |

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Table 1.1: A summary of key policy and legislation impacting on the development of mental health social work in England and Wales

Indeed, policy over the last twenty years has fluctuated between the promotion of the social worker as a valued and distinct contributor to the mental health service structure and social work as an adjunct to an increasingly generic mental health workforce. On the one hand, The *National Service Framework for Mental Health* (Department of Health, 1999) highlighted the importance of workforce planning, in the context of professional expertise, to ensure that the skills mix and staffing profile corresponded to local need and projected future demand for services. This placed high value on the benefit of multidisciplinary assessments to ensure a holistic approach (Gibb et al, 2002). It was unambiguous in its insistence on the significance of social work to this workforce, with the result that social work became integral to service planning and provision (Woodbridge-Dodd, 2017). This introduction of a common agenda across health and social care was underpinned by a legislative framework comprised of the Health Act 1999 and the National Health Service Act 2006 which enabled multi-agency budgetary planning, delegation of organisational responsibilities and staff sharing by creating a Duty of Partnership between health and social care agencies in the delivery of services (Gibb et al, 2002).

The formalisation of integration held particular significance for social work in enabling health and social care services to, for the first time, operate with combined budgets and therefore, by extension, to build teams of combined professionals under a single organisational leadership. With the NHS in position as lead agency for mental health, this gave the option to reposition social work away from an 'outsider-as-partner' role and into an 'outsider-as-insider' role. This had the potential to be advantageous in terms of rapport building and granting access to shape a shared professional world, fitting with an understanding that integrated structures are essential to effectively integrated services (Reilly et al, 2003; Gibb et al, 2002). However, immersion into a health-dominated environment with a medicalised focus (Cummins, 2018) without a robust social model to support their approach left social workers in a position of isolation (Bogg, 2008), with their non-medical perspective marginalised (Nathan and Webber, 2010). Mental health social workers were left conflicted between the competing demands of their health-led working environments, their social care employers and their professional expectations (Bailey and Liyanage, 2012).

It has been argued that the evidence base for this push to integration was minimal, with the absence of a clear theoretical framework upon which to build a model of service delivery (Evans et al, 2012) compounding a lack of direction arising from role ambiguity (Gibb et al, 2002). This in turn has led to professional tension within teams (Gulliver et al, 2002) and increased the likelihood of managerialism and legalism taking precedence over professional interpretation (Wilson and Daly, 2007). While this might ostensibly represent a flaw in implementation, consideration of other aspects of recent mental health policy throw this into question.

Although the *National Service Framework for Mental Health* (Department of Health, 1999) might have been unambiguous, subsequent policy has been anything but. Despite a retained focus on partnership working within the *NHS Plan* (Duggan, Cooper and Foster, 2002), and the core principle of working across organisational boundaries enshrined within the current *No Health without Mental Health* policy (HM Government, 2011), attention on the potential contribution of specific professionals became eroded over the last decade, with a growing emphasis on development of more generic mental health practitioners. *New Ways of Working in Mental Health* (NIMHE, 2007) signposted this change in emphasis in explicitly prioritising the capabilities of individual practitioners over professional roles, while reviews of the Care Programme Approach introduced a requirement for skills and competencies to become universal across the workforce rather than specific to particular professionals (Department of Health, 2008). In terms of overarching focus on professional specialisms, it is possible to chart a shift within the principle mental health policies. While the *National Service Framework for Mental Health* (Department of Health, 1999) specifically identified the range of professional specialisms required to deliver a holistic and comprehensive mental health service, the successor policy *New Horizons: Toward a Shared Vision for Mental Health* (Department of Health, 2009) emphasised co-ordinated, cross-organisational care provided by a workforce which "across all sectors have the knowledge, skills and attitudes necessary to deliver interventions" (Department of Health, 2009, p. 106). The following (and current) policy, *No Health without Mental Health* (HM Government, 2011) repeatedly emphasises the importance of cross-organisational and interagency working. Although underpinned by key objectives central to social work approaches (Duggan et al, 2002) it focuses on a generic approach to be adopted by "practitioners across

all services and sectors" (HM Government, 2011, p. 37). Professional distinctiveness is disregarded, although there is an emphasis on the importance of staff feeling valued and equal to colleagues in other health sectors. In this context of uncertainty and with a lack of directional clarity, it is perhaps unsurprising that social workers consistently show higher levels of work-related stress than their partner professionals in mental health settings (King's Fund, 2015).

Legislative reform has been similarly ambiguous. While the Mental Health Act 1983 has remained the principal legislation governing mental health interventions, the Mental Health Act 2007 both introduced a specific focus on social and psychological intervention for mental health need (Bailey and Liyanage, 2012) while simultaneously transitioning the Approved Social Worker to the Approved Mental Health Professional, opening the role to non-social workers for the first time in its history. Although social workers have remained the predominant profession operating in the role (Skills for Care, 2020a), the underpinning narrative of this change reinforces ideas of professional homogeneity evident within policy. This reflects the broader theme of redefinition – roles have become defined outside of professional specialisms, leading in turn to a high degree of overlap (Mackay, 2012) which contributes to the growing narrative of generic mental health professionals.

This conflict between genericism and professional distinctiveness continues to be reflected more widely across government health policy. The NHS *Five Year Forward View* (2014) promoted the use of "expert genericists" (NHS, 2014, p. 19) with an increased interest in the influence and input of generic primary care support rather than specialist secondary care across the NHS provision; a focus which was retained through the implementation of the plan (NHS, 2017). Simultaneously, however, it outlined the range of professional specialities which should be drawn from to build this workforce, which specifically includes medical, psychological and social perspectives. Interestingly, the current *NHS Long Term Plan* (2019) similarly prioritises an expansion of primary care support through a development of the Improving Access to Psychological Therapies (IAPT) programme to deliver a service to a greater number and broader range of those experiencing common mental health problems. This prioritises a specific intervention approach rather than the skills range of a diverse professional workforce and is further reflected in the intended provision for secondary

mental health services, which are planned to be remodelled and refocused to offer "access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use" (NHS, 2019, p. 69). Despite this shift in emphasis, however, in its *Five Year Forward View for Mental Health* the Mental Health Taskforce (2016) raised specific recommendations for a mental health workforce which reflected a move back to professional diversity and the use of multidisciplinary practitioners to develop an effective skills mix to meet mental health need. These recommendations elicited a positive response from the government, with a commitment to deliver a strong multidisciplinary workforce, and acknowledgement of a specific role for the delivery and development of mental health social work (HM Government, 2017).

Indeed, despite this apparent shift toward generic practice, mental health social work as a specialism has received both financial and policy attention in recent years. Significant funding has been invested in the Think Ahead programme, offering a fast track, mental health focused route to social work training (Clifton and Thorley, 2014), while the *Social work: improving adult mental health* initiative (Department of Health and Social Care, 2016), which aims to assess the effectiveness of social work in context, has resulted in the implementation of an operational definition of mental health social work comprising of aspirational aims and statutory obligations into national policy (Allen et al, 2016), supporting the idea that social work is underused in generic service brokering and care coordination (All-Party Parliamentary Group on Social Work, 2016).

Despite this commitment to both developing (Department of Health, 2016) and defining (Allen et al, 2016) mental health social work through policy and financial commitment to specialist training, mental health policy overall fails to demonstrate where professional specialisms might be used effectively within the frontline delivery of mental health services. Even where policy considers specific approaches, these consider action more at an organisational level, while the delivery of services is ill-defined and amorphous, as illustrated in the Department of Health (2014) *Wellbeing: Why it matters to health policy* which emphasised the necessity of, and potential approaches to, supporting wellbeing, but correspondingly focused action on reviewing evidence, communication and developing local

policy. While arguably the minutia of service delivery is an inappropriate focus for national policy, this does leave NHS and local authorities with a dearth of information regarding how best to create the service provision which meet the policy objectives

This lack of guidance can perhaps be explained by moves in the last decade toward a more localist approach, moving from the Thatcher era of 'no society' to the Cameron era of 'big society' (Scott, 2010), whereby health service provision can be commissioned in line with local need and priority rather than in line with a national agenda (Wilberforce et al, 2015). Arguably this may have had a multi-directional effect in generating unintelligibility, explaining both the apparent contradictions within policy and the wide diversity within the service provision on a national scale and, indeed, Fitzpatrick et al (2020) question the validity of such localist approaches with marginalised populations. Critically, they highlight the lack of specialist local knowledge of complex challenges and the difficulty for marginalised populations in establishing an effective voice in local priorities as strong drivers opposed to such local determination of provision, positioning local knowledge as prospectively unsafe and insufficient in meeting needs in these contexts. The fact that diverse mental health service provision has in turn failed to indicate an obvious contender in terms of effectively modelling a mental health service which successfully positions the professionals within it and could in turn be used to inform policy from the grassroots level suggests that such arguments should be given serious consideration.

## 1.7 A diverging of paths: the increased complexity of devolution

The fractured complexity of the mental health landscape during the opening decades of this century has been compounded by the separation of the four countries of the UK following the formal processes of devolution. Referenda in Scotland and Wales in 1997 and Northern Ireland in 1998 spoke in favour of devolution from the UK government across all three nations (Ducos, 2006), resulting in the implementation of the Scotland Act, 1998, creating a devolved Parliament in Scotland and the Government of Wales Act, 1998 and the Northern Ireland Act, 1998, establishing National Assemblies in both Wales and Northern Ireland (Farrell and Hann, 2020; Ducos, 2006). A key aspect of devolution related to the control of health and social care provision in all three nations.

Although similar on a casual inspection, these processes of devolution were markedly different both in terms of the context and the legislative framework for change. Although the UK was ostensibly one nation, governed under the purview of the UK government, for both Scotland and Northern Ireland, the context of health and social care devolution represented a natural progression. Independence from England was built into the legislative frameworks of both nations. Northern Ireland had self-governed from the inception of the Irish Free State until the commencement of the Troubles in 1972, with a number of unsuccessful attempts to re-establish this over the subsequent decades (Torrance, 2022). Scotland had retained a degree of autonomy over certain aspects of state provision, including in relation to health, since its unification with England in 1707 (Gray, 2021; Carrell, 2013), with home rule as a topic of discussion dating back to the late nineteenth century. The National Health Service (Scotland) Act, 1947 and the Health Services (Northern Ireland) Act, 1948 had established National Health Services independently to that established in England, albeit through mirroring legislation (Elder, 1953) and this paved the way for the development of independent systems, legislation and policies. Not surprisingly, therefore, Scotland and Northern Ireland developed unique legislative frameworks and systems both for mental health (Gray, 2021) and social work (Brodie et al, 2008; Pinkerton and Campbell, 2002) prior to devolution.

The Northern Irish and Scottish context for mental health social work exists within a devolved system which is beyond the scope of this thesis to discuss in full. Wales, however, represents a markedly different context for devolution rooted more closely within the development of mental health social work discussed thus far. The historic independence aspects which underpinned both the Northern Irish and Scottish health and social care systems were notably less prevalent in the Welsh context. Uniquely among the UK nations, a separate legislative system for health and social care was not established for Wales to the one enacted in England. Mental health and social care provision for both nations operated under the same legal system (Gray, 2021, Scourfield et al, 2008) meaning in these aspects, prior to devolution Wales was indistinguishable from her neighbour to the east.

It is perhaps not surprising therefore that appetite for devolution in Wales was markedly different than in the other devolving nations (Ducos, 2006; Roberts, 2011), with the Welsh 1997 referendum returning a fractional margin in favour of devolution by comparison to majorities of 74% and 71% in Scotland and Northern Ireland respectively (Ducos, 2006). The impact in terms of mental health social work was immediately noticeable but perhaps less impactful than might have been expected. The Government of Wales Act 1998 positioned health as a conferred executive power rather than a legislative, meaning that while the newly formed National Assembly for Wales could pass secondary legislation, they could only do so with the UK government's approval and Wales was still bound by the national primary legislation (Harrington et al, 2021). As a result, although Welsh policy diverged quickly from English policy with the *Adult Mental Health Services for Wales: Equity, Empowerment, Effectiveness, Efficiency* strategy (2001), the underpinning Mental Health Act legislation remained unchanged. Hannigan (2022) suggests that this policy divergence was significant, with Wales adopting a localised focus to mental health provision which reflected local needs and communities, rather than the national level specialisms more evident in corresponding English policy. The underpinning principles of equity, equality, empowerment and effectiveness were ratified in the subsequent *Adult Mental Health Services: A National Service Framework for Wales* (2002) and *Revising the Standard: The Revised Adult Mental Health Service Framework for Wales* (2005).

These devolved Welsh policies, by contrast to their English counterparts, reflected a distinct space for social work input. In addition to the underpinning principles, they introduced eight standards for service intervention, which promoted social inclusion, empowerment and normal daily living explicitly as the first three (Welsh Assembly Government, 2002; 2005). However, in the context of understanding professional contributions to the overall vision intended by the policy, the lack of clarity evident in England was mirrored in the Welsh context. Although the eighth standard for practice called for a mental health workforce "sufficient in numbers, well motivated, well trained, well led and well supported" (Welsh Assembly Government, 2005, p. 30) and identified "medical, nursing, psychological and social care" (Welsh Assembly Government, 2005, p. 5) as the key provision areas, how this was intended to be operationalised remained less clear. Staff were identified as a homogenous group with an anticipated broad skill range, suggesting an approach rooted

either in specialised genericism, or, given the preceding local focus, a deliberately omitted overarching strategy for how the workforce would be structured and services delivered. Welsh social work therefore appeared to have a clear space with mental provision, but no expressed intention for how it would occupy that space.

The fuller devolution of health and social care powers under the Government of Wales Act, 2006 has moved to address this, granting primary law-making powers which enabled the Welsh government to divert from the English legal framework (Harrington et al, 2021), a diversion subsequently enacted in the Mental Health (Wales) Measure, 2010 (hereafter, the *Measure)*. While the subsequent *Together for Mental Health* (Welsh Government, 2012) policy reflected similar developments more widely within the UK (Hannigan, 2022), and the *Social Services and Well-being Wales Act* (2014) mirrored closely the reforms to social care introduced in the *Care Act* (2014), the *Measure* positioned the Welsh approach to extend beyond ideas of health and support to focus on a broader concept of wellbeing (Clifton, 2021). Drawing on World Health Organisation definitions of wellbeing as surpassing the absence of discomfort and incapacity to encompass a more holistic consideration of physical, mental and social condition (Welsh Government, 2012), the *Measure* reflected a divergence in legislative priorities in the Welsh context.

Unlike the Mental Health Act*,* 1983, which focused on detention and compulsion in relation to mental health need and treatment (Hannigan, 2022), the *Measure* prioritised rights, recovery and quality of care (Hannigan, 2022; Clifton, 2021). Central to its provisions were the rights of service users, with the legislation clearly setting into law entitlements to assessment, explicit care and support planning, care co-ordination and advocacy extending beyond that afforded to those detained under the Mental Health Act*,* 1983. Alongside this was a legal expectation to engage service users in planning both their own and the wider service care provision (Welsh Government, 2012). In this, the *Measure* reflected the more rights-based focus of the other devolved UK nations over the risk-management focus of the UK government in England (MacKay, 2012). However, while in principle this suggests a significantly different landscape for Welsh mental health social work than for its English counterpart, the practice reality appears less clear cut. Evidence comparing care provision in England and Wales suggested that while senior practitioners and managers spoke

positively regarding the *Measure*, frontline practitioners and service users reported comparable experiences of involvement and wellbeing focus across both countries (Simpson et al, 2016), despite reports to the Welsh Government from the same time period suggesting a positive impact (Roberts, 2021).

The apparent contradiction inherent here may in part be explained by the complexity of the legislative framework that mental health social work in Wales operates under. While legislative power is devolved in most instances, including health and social care, reserved powers that remain with the UK government can cause conflict (Harrington et al, 2021) and limit the capabilities of the Welsh government to legislate in areas which are ostensibly devolved (Welsh Government, 2019). For mental health provision, this is most clearly evident in relation to the justice system. As justice remains a reserved power held by the UK government, both the Mental Capacity Act 2005 and the Mental Health Act 1983 remain in force in Wales; the former due to the identification of capacity as a legally determinable state, and the latter specifically in relation to detention of restricted patients (Welsh Government, 2019). The operationalisation or amendment of the elements of the law which are devolved is therefore challenging. Acknowledging the complexity of managing the interface between mental capacity and mental health in general (Welsh Government, 2019), mental health social work in Wales must also balance the rights-focused emphasis of the *Measure* and the corresponding Welsh policy, with the control-focused aspect of the Mental Health Act*,* 1983, without creating disparity between those subject to Mental Health Act provisions within the justice system and those outside it. In addition, while administration of this Act is fully devolved for all those it applies to, aside from those within the justice system, mental health social work in Wales must balance the policy drivers of a heavily rights and wellbeing-based system with the demands of a legislative framework whose compliance with internal standards on human rights has been called into question (Szmukler et al, 2014). Perhaps nowhere, therefore, is the lack of defined professional framework for mental health social work more apparent than in the Welsh context. Mental health social work in this context is driven both by the left-wing ideologies of the Welsh Labour government and the right-wing ideologies of the UK Conservative government as made apparent in the legislative frameworks which inform practice.

Despite this, mental health social work provision continues to evolve in Wales. Recent policy developments have seen an explicit focus on workforce development and planning in both health and social care. This acknowledges that the effective use of these workforces in an integrated fashion cannot be left to chance and acknowledges the need to position the mental health workforce in its own right independent of a wider overview (Social Care Wales and Health Education and Improvement Wales, 2020; Welsh Government, 2020). While these workforce reviews remain ongoing and effectiveness will ultimately be demonstrated in practice, the direction is promising in terms of expressed intent to establish a clear framework for the mental health social work contribution to service delivery.

## 1.8 Understanding the present in the context of history: contemporary mental health social work

Social work in general, and in mental health in particular, is a profession which has arisen and developed in an organic and responsive manner to the developments in the world around it. It has been shaped and informed by its political, economic and social circumstances, whilst also trying to establish its own identity and professional remit. In this it has been perhaps partially successful; social work is now legally recognised as a profession worthy of protection (Jones, 2014), although it arguably fails to meet accepted definitions of a profession given its failure to establish a unique influence or exclusive specialist knowledge in any given area of practice (Brodie et al, 2008). This challenge is compounded by the inextricable link which has been drawn through decades worth of legislative frameworks between the social worker as professional and the local authority as state agency (Harris, 2008).

Nathan and Webber (2010) have proposed that social work within mental health settings has been subjected to a process of bureaucratisation, with practice becoming procedural within a dominant medical hierarchy and approaches dominated by medical perspectives hinged upon notions of diagnosis and predictability (Davidson, Brophy and Campbell, 2016). This is not necessarily a challenge unique to social work in this multidisciplinary setting,

where procedural bureaucratisation will affect any professional working within it. However, it perhaps does affect social work more intensely given the organic development of the profession and its loosely defined remit (Brodie et al, 2008), as well as its increasingly common position as a local authority agent in this health dominated environment (Bailey and Liyanage, 2012).

Compounding the challenge for mental health social work, the provision of mental health services has similarly arisen in a haphazard and reactionary manner, frequently driven by crisis response and local agendas and generally in isolation from any social work specific developments or initiatives. Localism agendas without appropriate oversight and direction have resulted in services designed according to local need but not automatically with the specialist local knowledge to inform them (Fitzpatrick et al, 2020; Docherty and Thornicroft, 2014). As a result, poor workforce planning is endemic (Evans et al, 2012), with teams built pragmatically and without recourse to a theoretical or empirical rationale (Burns and Lloyd, 2004). Instead, team structure is based primarily upon either historical convention within the area (Duggan et al, 2002) or upon the practical availability of staff (Beinecke and Huxley, 2009), reinforcing the structural discrimination inherent in services which lack oversight and therefore evaluation (Docherty and Thornicroft, 2014). Variation has become non-purposive in terms of maximising service delivery and instead exists by rote (Wilberforce et al, 2015). Evans et al (2012) highlighted the impact of poor overall workforce planning, establishing the extent to which compliance with expectation, historical arrangements, and lack of communication between health and social care determined team structures, with less than 10% of services built around a multidisciplinary model. Services in this context are built to the convenience and expectation of what is available, rather than being structured around any articulated objective, despite an identified requirement for optimal staffing to be built around the nature and scope of local demand (Wilberforce et al, 2015).

Mental health services exist once again in a state of flux. The Mental Health Act (1983) is again under review, with proposals to increase the focus on autonomy, choice and respect for the individual (Department of Health and Social Care, 2021). The recently released Draft Mental Health Bill (Department of Health and Social Care, 2022a) amends rather than replaces the 1983 Act and, while still requiring pe-legislative scrutiny, does suggest a move

toward a wider recognition of human rights, bringing English law more in line with the Welsh model (Keen, 2022). Furthermore, while the Welsh government reviews the structure and composition of its mental health workforce (Welsh Government, 2020), the Care Programme Approach, dominant in mental health care in England for three decades, is being supplanted by a new Framework for Community Mental Health. This draws on previously recognised localism agendas to position mental health support firmly within local communities, with services intended to exist as a support and adjunct to this (NHS England, 2019a). Narratives around this shift present initially positive notions of professional distinctiveness and multidisciplinary collaboration, with an emphasis on the move away from generic care co-ordination to more holistic, personalised approaches to care (NHS England, 2021). This would seem to position social work as critical to delivery, however, closer scrutiny indicates an emphasis on involvement of the voluntary and community sector and the significance of Care Act 2014 – relevant to social workers in local authority contexts but not, by default, to mental health social work - and section 17 Mental Health Act 1983 compliance (NHS England, 2021). Social functions of the new provision focus on practical interventions aimed at solving immediate and tangible social problems around housing, employment and finances (NHS England, 2021) often best addressed outside the remit of the mental health professional (Clarke, 2017). By contrast, narratives of rights and social justice linked to addressing structural inequalities, advocacy and challenging stigma and discrimination which frequently underpin social work approaches are notably absent. It remains to be seen therefore, to what extent the social work contribution to this new mental health framework expands beyond the provision of the statutorily defined responsibilities, although ongoing work on a NICE guideline for social care in this context suggests emphasis on assessment, family interventions, community signposting and crisis response may be prominent (NICE, 2021).

## 1.9 Conclusions

This chapter has explored in detail the development of mental health social work specifically in the context of its policy and legislative frameworks and how those have been influenced by the wider social, political and economic contexts. The outcome is contradictory, presenting a system which vacillates between centralising and marginalising the social work

contribution to mental health, and in prioritising and minimising the criticality of integration and multidisciplinary working. The enforced division of health and social care implemented alongside the much-lauded introduction of the Welfare State (Freeman, 1998) both disrupted the developing professionalisation (Queen, 1922) of mental health social work in particular and reflected a fractured set of priorities which have continued to be reflected in policy developments and organisational through to the present day. Differing local authority and NHS priorities, driven and underpinned by mental health and social care policy and legislation pull mental health social work in a range of different, potentially opposing directions.

Central to understanding these contradictions, and their impact on mental health social work is an awareness of the extent to which social work is vulnerable to fluctuations in social priorities, dominant political ideologies, organisational drivers and contextual factors (Bailey and Liyanage, 2012). Rooted within organisational contexts driven by policy and legislation, the development of mental health social work has shown a clear narrative that positions it as a victim of circumstance, with its practice actions increasingly influenced and dominated by right-wing and neoliberal ideologies that contributed to a complex tapestry of policy directives which increasingly bureaucratise and managerialise the social work contribution (Nathan and Webber, 2010), and which the profession lacks a robust identity with which to counter. Mental health social work sits at a crossroads, with its contribution unclear between the competing demands of the medically dominated approaches of health, or the legislatively governed emphasis of the local authority.

The history of mental health social work is one of reaction, evolution, improvisation and compromise. In this context, it is perhaps unsurprising that the profession has struggled to position itself effectively within the existing hierarchies of practice. Without a consensus on its rationale for inclusion, defending or understanding the mental health social work position in the context of constantly shifting priorities is challenging. If policy and legislation are so influential on the practice of mental health social work, it seems prudent therefore to consider how social work's professional status acts as a corresponding influencer on practice.

# Chapter 2 - How do we know who we are? Understanding professional identity in mental health

The haphazard evolution of mental health social work outlined in the previous chapter arguably runs contrary to the development and establishment of a robust and easily definable professional identity. However, this is not a difficulty restricted to either the mental health context or social work; professional identity is a nebulous and ill-defined concept in all fields, approached from a range of perspectives and developing multiple meanings (Wiles, 2017a). Nonetheless, the contextual influences of policy, legislation and wider societal views already established require a similar understanding of what professionalism means in a mental health social work context. To position how mental health social workers view their role, and the extent to which it is influenced by the context of practice, it is critical to first establish the existing understandings of professionalism in social work, mental health and mental health social work.

Social work more broadly has been described as a profession in crisis, viewed as being of low status (Duggan et al, 2002) and subject to negative or dismissive (Wain, 2016) media coverage, although this is rare in mental health social work specifically (Leedham, 2022). Devalued professional identities have a direct impact on professional effectiveness, with image and competence closely entwined (Osburn, 2006). Where competence is poor, image is negatively affected, perhaps understandably. However, the reverse also holds true; where image is devalued, competence in turn can be restricted or disregarded regardless of actual performance (Osburn, 2006). In the context of the multidisciplinary environment, dominated by medical practitioners with generally more well-understood professional competencies, the concern for establishing the professional contribution of social work is tangible; in order for social work to be valued for what it *does*, it is necessary to also be valued for what it *is* (Wolfensberger, 2011a). However, to understand professional identity in the specific context of mental health social work, it is necessary to explore professional identity more broadly, both as a concept and within context. Developing a clear picture of the more specific elements of the professional identity of mental health social workers requires an understanding of what is unique to the intersection of social work and mental

health to enable development of a robust identity and the corresponding exercise of professional competency, and what is more generic to the concept of professionalism.

With this under consideration, this chapter will consider professional identity as an abstracted idea, which can then be applied to both the practitioner and practice contexts. Starting with a conceptualised professional identity, this will then be explored through the lens of social work, allied health professionals and the practice context to draw out the points of intersection that position the mental health social worker.

## 2.1 Conceptualising professional identity

Although it has formed a substantial element of debate within health and social care over recent decades, concepts of professional identity have been described as under-researched and poorly theorised (Gent, 2017; Sims, 2011). The literature across a range of health and social care settings postulates the characteristics of professional identity widely. On the more tangible end of the scale, features include knowledge and theoretical underpinnings (Terry, 2019; Hughes, 2001), the exercise of judgement and autonomy (Fitzgerald, 2014; McCrae et al, 2014; Hunter and Segrott, 2006), professional education and research capability (Terry, 2019; Sims, 2011) and specific defined traits, tasks and competences (Best and Williams, 2019; Wiles and Vicary, 2019).

While such approaches are powerful in their specificity, being rooted in such strongly pragmatic and practical definitions, however, seem to offer an unsatisfying explanation of distinctive professionalism, and risk a normative categorisation that ignores the inherent power dynamics of practice (Dent, 2017). The traits listed above are often understood in terms of their uniqueness contributing to professional identity (Elvey et al, 2013), but uniqueness both in knowledge and professional practice is a subjective concept and open to interpretation from individual perspectives (Wiles, 2017a). Social work in particular holds a reputation for drawing on a diverse range of disciplines to inform its knowledge base, and Trevithick (2008) argues that, in dealing with the complex realities of social work practice, it is necessary to go beyond the theoretical and empirical knowledge bases to draw extensively also on practice and experiential knowledge, both of which are held in lower

regard. While professions seek to attain a level of distinctiveness as a matter of priority (Gaskell and Leadbetter, 2009), such distinctiveness needs to be interpreted and categorised as pertaining to the label of professional (Hurley, 2009). Technical specialisations are an inadequate quantifier for professional status in all fields and, by extension, therefore, it is difficult to interpret professional identity as an objectively measured phenomenon, suggesting it should rather be viewed as a socially constructed concept, wherein the perceptions both of the self and of others are critical in it becoming both established and maintained (Elvey et al, 2013).

More abstracted concepts of professional identity draw upon and incorporate this subjective understanding, with both individual perceptions and social interaction seen as critical to its establishment (Adams, 2013; Gaskell and Leadbetter, 2009; Ashforth et al, 2008; Ashforth and Mael, 1989). In terms of personal attributes, Schien (1978, cited in Best and Williams, 2019) describes this as "the relatively stable and enduring constellation of attributes, beliefs, values, motives and experiences in terms of which people define themselves in a professional role." This significance of personal attributes being central to professional identity is echoed across the literature, with the suggestion that internalisation of positive professional identity is linked to a sense of worth and purpose (Elvey et al, 2013) and, indeed that professional identity is an attribute of an individual rather than of a group (Joynes, 2018). Sims (2011) draws a distinction between professionalism, as the identity held by a group (such as social workers) and professionality, as the attitude toward identity held by an individual practitioner which in turn influences how professionals behave in and respond toward practice challenges (Best and Williams, 2019).

This individualistic perspective may go some way to explain the challenges in theorising professional identity. As is the position held in this thesis, Joynes (2018) highlights that there is no homogenous experience of professional identity, with sub-cultures and sub-identities prevalent within professions introducing a level of diversity which eludes easy classification. Furthermore, professional experiences are affected both by the individual's personal characteristics (Wiles, 2017a) and by their experiences (Rasmussen et al, 2018), past, present and future. This level of individual variation presents challenges in developing

all-encompassing definitions which do not become either exclusive or so broad ranging as to be verging upon useless.

Ideas of professional identity are subject not only to internal processing, however, but also to external scrutiny and categorisation. This is both internal and external to a profession; without discounting the significance of the individual, professional identities are a collective representation of a particular group (Best and Williams, 2019) and therefore require a degree of consensus within that group. Professional identity is correspondingly shaped and driven by goals beyond those of the individual (Murray, 2013). Perhaps unsurprisingly then, fostering professional identity has become a key aim of education within health and social care (Wiles, 2017a), with the expectation that it will be critically shaped and developed through the process of education and experience (Terry, 2019; Adams, 2013). In this context, the significance of continuing professional development becomes more tangible (Harmer, 2010), although this also lends suggestion to the fluidity of professional identity as sinuous and unfixed, an identity in a state of continual change and development, which in turn presents challenges to the idea of definition.

King and Ross (2004) argue that the personal experience of professional identity is best viewed through a lens of phenomenological constructivism, whereby professional identity is perceived, interpreted and reflected through a broad range of invested parties, which in turn contributes to the ongoing review and development throughout a professional's career. Social identity theory (Tajfel and Turner, 2004) holds relevance here, in the context that professional groups can become externally defined and presumptions about professionals will in turn be drawn from the assumptions held about these groups. Misunderstanding and flawed conceptions, potentially linked to a poorly articulated professional identity, risk the potential for stigma and stereotyping (Hughes, 2001) and associated distancing from a professional role, such as the propensity for adult social workers to distance themselves from child protection work. Such threats to identity will have relevance only to the extent to which professionals identify with their assigned groups (Gaskell and Leadbetter, 2009).

Significant to this consideration is the concept that professional identity relates to a singular identity, such as social worker. Sims (2011), in looking at dual qualified professionals, highlighted how this assumption could run contradictory to personal interpretations of professional identity, causing frustration for practitioners. It could be argued that all professional identities are multi-faceted, with either numerous aspects to the identity itself (Elvey et al, 2013) or identifying with a particular aspect of practice, such as mental health social worker as opposed to a more generic social worker (Joynes, 2018). Indeed, in this vein, McCrae et al (2007) highlighted that professional identity was not restricted to an externalised conception of role, but could be linked either to professional grouping, employment context or an amalgamation of the two.

The relevance of context to professional identity has not gone unnoticed. Rasmussen et al (2018) argue that professional identity is comprised of the three-way interaction of self, role and context; with the three elements of *what, who* and *where* all influencing and being influenced by each other. This supports McCrae et al's (2014) contention that professional identity involves the pursuit of a role to achieve optimal positioning within a contextual hierarchy, and positions it as a conflation of group design, external forces and internal attributes. External forces in this context can be argued to refer not only to the shaping of professional identity by external perspectives and expectations, but also to the influence of the context of practice and how this interacts with, and indeed restricts, perceptions of role (Hunter and Segrott, 2008). As Ashforth et al (2008) posited, professional identity becomes an amalgamation of both self and situational definition, with personal identification shaped and influenced by the wider contextual factors surrounding it.

Social role valorization (Wolfensberger, 2011a) can contribute to understanding this interplay of factors more vividly. Arising in the field of intellectual disability, this theory models that social roles can be protected through the enhancement of image and competency. Although not specifically aimed at professional roles, social role valorization prioritises the support and enhancement of social roles seen as valuable which are in turn at risk of being devalued (Wolfensberger, 2011a) in the aim of ensuring positive social outcomes, and this is arguably particularly relevant for social work roles seen as low status (Duggan et al, 2002). Non-valued roles are associated with ideas of deviance, in this case

professional deviance, and correspondingly disregarded and excluded, with a corresponding impact on future behaviour (Wolfensberger, 2011a; Osburn, 2006). For the social work role to be valorized, it needs to occupy a respected position within the health and social care hierarchy, without which its contribution risks being minimised in favour of more dominant health-based discourses (Saks, 2016), with the corresponding outcome that social workers may be less willing to present their social perspective to future discussions.

Context in this setting is key, echoing previous research positioning professional role as contextually driven (Ashforth et al, 2008; Ashforth and Mael, 1989). Wolfensberger (2011b) highlights critically that social role valorization relies on a principle of persuasion and the recognition, rather than demanding, of role value. In this conceptualisation, the outsider perspective is critical to the success and acceptance of the social role, and this can differ based on context. The medical professional's perspective and expectation potentially differs from the fellow social worker; priorities, values and ideas of effectiveness informed by professional knowledge, experience and understandings will colour the extent to which the social work role is seen in a positive and valuable light. Perhaps more importantly, this suggests that professional roles, and by extension, professional identity can hold different value in varying contexts. Social workers, in aiming to establish a robust professional identity, may need to emphasise and promote different aspects of this, to demonstrate the value of their role in any given context (Wolfensberger et al, 1996). This in turn risks developing a multi-faceted identity, whose valuable aspects are externally defined and specific to role, potentially to the detriment of the internal conceptions of professional priorities.

Indeed, the professional's role would appear to be a significant contributor to the idea of professional identity beyond the context of specific tasks postulated earlier. Discussions around professional identity have frequently posited role as central (Best and Williams, 2019; Harmer, 2010), with contribution extending beyond a task focus to encompass more fully what a practitioner brings to a practice setting in terms of skills, knowledge and experience. Rasmussen et al (2018) suggest that adoption of professional identity is an enabling factor in understanding, and by extension, enacting professional roles through the capability to position them within a professional framework. Issues around role ambiguity

and the blurring of boundaries have been linked to concerns around burnout (Terry, 2019), stereotyping (Hughes, 2001) and confusion and professional strain (Brown et al, 2000; Adams, 2013), while within a multidisciplinary setting, confusion over roles contributes to poor teamwork and ineffective working (Brown et al, 2000). This perhaps explains why professional roles have been central to discussion over recent decades (Brown et al, 2000) and why the question of whether practice complements or challenges ideas of professional identity dominate (Harmer, 2010).

Role theory highlights the complex interplay between the assigned activities linked to roles and the significance of the practice context. Role theory positions roles as explicit direction, which become internalised once assigned and influence the behaviours and practices of individuals and enable understanding and categorisation of their contribution (Goffman, 1959). In this way, the focal professional is influenced not only by their internal understanding, but also by the external expectations of the role surrounding them, namely from those individuals and organisations which hold vested interests in the role to be undertaken (Hughes, 2001).

Where role expectations are explicit, this can arguably be useful for any professional in establishing their identity; however, difficulty is encountered where role expectations are non-specific (Hughes, 2001) or where the requirement for flexibility has necessitated some degree of ambiguity (McCrae et al, 2014). The nature of role blurring, role extension and role erosion which is evident within health and social care settings can contribute to this sense of ambiguity (King and Ross, 2004). In this context, role extension refers to the adoption within a professional identity of additional tasks and activities which would not have conventionally been deemed part of that professional identity, while role erosion refers to the reallocation of tasks, often to non-qualified practitioners, which can be interpreted as a weakening or dilution of a professional role. Crawford et al (2008) suggests that this degree of ambiguity can contribute to difficulties in establishing and maintaining a professional status, necessitating practitioners to generate a performance which endeavours to secure a level of recognition that is congruent with their internalised sense of identity.

Defining professional identity is therefore a challenging and elusive task. Professional identity is influenced by internal modelling, external perspectives and contextual factors, with more pragmatic task-centred, technical definitions falling short of positioning this comprehensively. Many of the elements which appear to contribute to professionalism are subjectively defined, contextually influenced and externally impacted in a three-way interaction that challenges a singular definition. Critically, perhaps, theoretical understandings of role identities repeatedly highlight the significance of external factors in directly influencing and challenging the successful adoption and enactment of roles. For social workers, operating in a broad range of roles influenced by a wide variety of perspectives and in vastly differing contexts, it is perhaps unsurprising that there is an evident divide between academic discussions of professional identity and the realities of practice for those attempting to enact it (Joynes, 2018). It is critical therefore to consider this dilemma with more specific reference to the professional population under study: the social worker.

## 2.2 A contested profession: professional identity in social work

Social work is by its very nature contested (Thompson, 2009) and ongoing debate about the role and contribution of social work evidences a profession perceived to be in a state of identity crisis (Webb, 2017; Allen, 2014; Social Work Taskforce, 2009; Scottish Executive, 2006). Professionalism and professional leadership are both integral to the core capabilities of the profession, as set out in the Professional Capabilities Framework (BASW, 2022), although precisely what these capabilities might involve is perhaps less clearly defined. Nonetheless, feedback from the profession has viewed them as integral in identifying 'successful' social work applicants (Wiles, 2017a) and the recent review of social work education identified that the critical components of the social worker were of the practitioner, the social scientist and the professional (Croisdale-Appleby, 2014), reflecting a perception of social work that has sustained for over sixty years (Younghusband, 1947).

Despite this, however, Sims (2011) highlights that social work, like nursing, is viewed as a semi-profession, caught between occupational autonomy and organisational control. Social work is frequently seen by other professions as over-bureaucratised (King and Ross, 2004),

while both Wiles (2017a) and Canavan (2009) suggest that social work in UK contexts is overly biased toward its statutory roles, with an overly heavy state influence on its activities of practice. Queen's (1922) definition of the social worker as aiming toward professional status but in a state of transition was echoed by later scholars (Toren, 1972; Etzioni, 1969) and appears to continue to hold true one hundred years later. Emphasis continues to be on technical, academic knowledge which is given precedence over the more tacit and experiential knowledge that drives social work practice with equal vigour (Trevithick, 2008). A focus purely on specific tasks, driven within policy and legislative frameworks, are seen as overly bureaucratic and identified correspondingly as a professional weakness (Nathan and Webber, 2010).

The UK context is of specific relevance here. Social work is a global profession, with social work practice evident in 144 countries (Weiss-Gal and Welbourne, 2008). Roles and ideas of professional identity are heavily influenced by these national contexts; while overarching ideas of values as central to social work apply seemingly universally, the nature of these values, and the corresponding form that social work roles take are uniformly locally influenced (Ornellas et al, 2018). Higgins et al (2016) suggested that social work is caught within a paradigm debate between a broad and holistic aspirational approach, most commonly seen in educational settings, and a narrowly confined statutory approach prevalent in practice. Similarly, Wiles and Vicary (2019) highlighted that English social work in particular is heavily influenced by policy expectations around competencies and standards, which correlate poorly with wider international ideas around professional identity as a collective sense of meaning. Nonetheless, this focus on standards perhaps explains the extent to which UK social work conceptualisations draw on task-oriented narratives.

Indeed, there are four key conceptualisations of the professional role of social work. On the more pragmatic end, social work is defined by its tasks and by its statutory duties (Canavan, 2009). Role in this context is divorced from any conceptualised position and becomes synonymous with specific activities (Hannigan and Allen, 2013), leading to an overemphasis on technical competence (Canavan, 2009). This context dovetails with an emphasis on risk management (Keddell and Stanley, 2017) which results in misperceptions of social work

among other professionals where contributions beyond the statutory obligations are not recognised (see, for example, Crawford et al, 2008). This has led to questions around whether the tasks of social work are even social work (Keddell and Stanley, 2017) and perhaps explains why social workers, more so than other health professionals become over-represented in management roles divorced from client interaction (Best and Williams, 2019; Workman and Pickard, 2008).

This task centric practice is proceduralised and prescriptive, placing social workers as politically branded agents of state control operating within comprehensive statutory frameworks (Keddell and Stanley, 2017; McLaughlin, 2010; Canavan, 2009; Webb, 2006). Use of care pathways and assessment processes represent restrictive 'technologies of care' which necessitate formulaic practice (Carey, 2015). However, social workers do not appear to have adopted such restrictive practices unquestioningly. Carey (2014) identified representations of cynicism in how social workers practice which challenge such practice rhetoric, while Buckland (2016) argued that social workers work despite rather than within the limitations of their statutory obligations.

Social work has also been defined in the context of its specialist knowledge and access to social care resources (Emprechtinger and Voll, 2017), which fits within definitions of professionalism which privilege distinctive knowledge. Research has shown that mental health legislative specialisation is seen as a specific social work professional role, with the development of social work skills a key consideration for practitioners from other professional backgrounds undertaking the role (Social Work England, 2022) but more universally, social work's lack of distinct contribution has been supplanted by expectations arising from their status as accessors of local authority resources (Emprechtinger and Voll, 2017). However, technical knowledge alone is arguably insufficient to describe a profession, as experiential practice knowledge enables professionals to identify when technical knowledge is relevant (Webber, 2013). Understanding of social care systems and processes are insufficient as a denote of professional identity, if the practitioner in question is unable to say how or where these should be applied. Furthermore, within the UK context, recognition of social work knowledge and experience from an external eye is weaker than would support the concept as knowledge as defining professionalism. While within the

academic community, the UK voice on social work is stronger, within wider societal debates around social policy issues, the voice of social work is almost unheard (Sicora and Citroni, 2021).

Knowledge as the bedrock of social work professionalism is arguably questionable in the context of a profession which works across knowledge bases (Webber, 2013) and within the gaps of other professional practices (Wiles and Vicary, 2019), with nursing (as the other semi-profession) similarly described as 'cherry-picking' the knowledge base to inform their practice (Hurley, 2009). Similarly, retaining and enacting professional knowledge in social work is challenging within rigid organisational contexts, focused on workload management and procedure to the detriment of a robust knowledge framework (Emprechtinger and Voll, 2017; McDonald et al, 2008) and potentially also dominated by professionals from other contexts. It has been suggested, therefore that social work's professionalism is best articulated in terms of *where* social workers practise; at the crossroads between systems, between organisations, individuals and environments (see, for example, Oliver, 2013; Long, 2011; Coppock and Dunn, 2010; Nathan and Webber, 2010). Social work in this context occupies an arguably unique position within a fluctuating network of social political networks (Long, 2011), crossing boundaries and disciplines (Oliver, 2013) to develop innovative and unique approaches to intervention (Evans, 2020). However, in the context of professional identity, this is potentially more of an obstacle than a benefit. As previously discussed, the significance of external perspectives in both defining (Hughes, 2001) and validating (Wolfensberger, 2011b; Ashcroft and Mael, 1989) the professional role, social work's position at the intersection of multiple external gazes, with varying priorities in terms of their expectations of the profession, draws the professional focus of even the individual professional into question.

Additionally, as previously discussed, social work's claim to autonomy in this context is questionable. Social workers are predominantly seen as agents of state control, disproportionately influenced by policy (Wiles, 2017a) and overly focused on and governed by statutory interventions (Canavan, 2009) and an emphasis on control (Bradt and Bouverne-De Bie, 2009). It is interesting to note that while Sicora and Citroni (2021) argue that social workers can act both as agents of and advocates against the state, they do so in

the context of their employer's position within the social structures (e.g. voluntary, statutory or private sector). The implicit assumption here is that social work's positioning on the boundary does not arise as a matter of professional choice, but instead from a structural necessity linked to the agency of employment.

Boundary positioning in this context arguably serves to weaken rather than strengthen a professional identity, with social workers side-lined and disregarded in favour of other, more prominent professional roles. Social work fluidity in working without rigid boundaries (Webber, 2013) can translate into professional compromise rather than professional flexibility, especially in the context of organisational and other professional demands (Emprechtinger and Voll, 2017). Their role is dictated by the policy remit of their respective organisations rather than by professional distinctiveness positions them as invisible and unacknowledged (Morriss, 2016a).

Payne (2006) proposes a three-dimensional social work model, positioning social work approaches as therapeutic, transformational and social order. The therapeutic aspect relates to relationship-building as a source of empowerment for clients which enables them to overcome disadvantage. The transformational represents social work's specific commitment to achieving and ensuring social justice, while the social order element relates to regulation of individuals and maintenance of social order. While Payne envisaged this model as multi-directional and complementary, social work practitioners have been dubious on the extent to which all three aspects can be simultaneously achieved, and it has been suggested that social work professionalism has shown an increasing bias toward and over-emphasis of the social order element (Canavan, 2009).

Despite this, social work remains rooted within a framework of human rights, social justice and professional integrity (BASW, 2012; Canavan, 2009), which has continuously influenced social worker self-narratives. Within this narrative, social workers adopt a person-centred perspective which centralises a rights-based and socially rooted outlook to practice, with social workers prioritising values within their work (Social Work England, 2021a; Clark, 2009) and bringing a unique social perspective to bear. Critical to this perspective is an unfailing focus on social justice and rights, enacting a commitment to the reduction of injustice and

the correction of moral wrongs affecting individuals (Clark, 2009). Webb (2015) posits that professional identity can be classified as distinctive, prestigious and externally defined by those not within the professional group. Within this framework values are positioned as the specific, tangible and visible characteristic which grants social work its particular distinctiveness.

Such broad sweeping claims are difficult to substantiate, however. The Professional Capabilities Framework is as vague in its definitions of social justice and inclusion as for professionalism (BASW, 2022). Viewing the use of values as an unproblematic tool to inform practice oversimplifies a complex interplay of social interactions and priorities (Dominelli, 2009) and ideas of empathic and person focused practice are arguably insufficiently unique to act as signifiers for professional status (McCrae et al, 2014). Indeed, it has been suggested that professional practice which foregrounds the client arises from a lack of clarity around professional role and is a defence against role ambiguity rather than being inherently person centred (Crawford et al, 2008). Contrasting Webb's (2015) assertion, Wiles' (2013) interviews with social work students positioned values as only one of three elements which combine to define social work, with identity existing as a separate concept alongside knowledge. This framing from within the profession suggests professional identity encompasses something beyond the attribution of values and knowledge so often associated with it.

Wiles (2013) subsequently suggests that professional discourse builds on shared social work traits, namely knowledge, autonomy, adherence to values and an altruistic helper stance. This assumes however a shared social work knowledge base, which does not account for professional specialisation and the associated fragmentation of skills and knowledge (Carey, 2014). Social work formal training in mental health, for example, is notably poor. Awareness outside mental health practice is weak (McCusker and Jackson, 2016) and, even within mental health services, issues have been identified around inexperienced and poorly informed social workers contributing to serious untoward incidents (Stanley and Manthorpe, 2001). Similarly, an altruistic perspective ignores the substantial social control agenda which underpins social work, and which is enacted through social work's undertaking of its legislative duties (O'Hare et al, 2013).

Weiss-Gal and Welbourne (2008) summarise the above distinctions of professional identification as aspects of the attributes approach, rooted in identifying core traits that distinguish professional activity from occupational activity. They argued that definitions of social work professional identity were rooted within this framework, which incorporated five key elements: a knowledge base, recognised professional authority, community sanction, an ethical base and formalised professional culture. In this context, professional bodies and external perceptions of social work are critical in establishing its professional basis, and challenges around the nebulous nature of social work's position within services and poor public perception may go some way to explaining the difficulties in establishing a professional foothold.

The attributes approach is largely atheoretical (Saks, 2016) and rooted within the practical structure of the role. As an addition to this attributes approach, however, Weiss-Gal and Welbourne (2008) draw on a second model for professionalisation, namely the power approach. Under this model, professional status is defined by the ability to establish and maintain control over a particular area of practice. Theoretically situated within social structures, this approach has been conceptualised extensively, however, the dominant narrative positions the professional as formally boundarying their work, supported by the authority of the state, to create an insider-outsider dichotomy, whereby the insider is privileged to exercise the power of the professional and the outsider is not (Saks, 2016).

From this dual perspective, Weiss-Gal and Welbourne (2008) developed an eight-aspect model for professional social work status. This incorporated the following key elements:

1. Recognition of professional status
2. Monopoly over areas of work
3. Professional autonomy
4. A distinctive knowledge base
5. Internally regulated professional education
6. Effective professional representation
7. Defined ethical standards
8. Standing and remuneration reflecting professional status

Evaluation of the model against professional descriptions from ten countries reflected narratives of social work as a partial profession, with some criteria met to some extent, albeit with variation across nations. Critically, in aspects over which social work could exercise its own control, professional status was more robustly established than in areas where this relied upon validation by an external agency (Weiss-Gal and Welbourne, 2008). Building upon this, there are further suggestions that social work does hold a collective identity which transcends national and contextual boundaries (Wiles and Vicary, 2019). Although seen as poorly fitting, rife with tension and fragmented, their study with multi-national social workers did identify thematic similarities around a passionate sense of self which, although poorly articulated, acted as a unifying factor. This was echoed by Stone et al (2021) whose survey of European social workers positioned mental health social work as contextual to its social and political context, but underpinned by shared specialist knowledge, a values driven approach and an alternative social perspective. Despite this distinctive contribution, however, the authors nonetheless concluded that mental health social work remained poorly defined, with problems in establishing professional status and identity and in establishing a clear role. This perhaps reflects Thompson's (2009) contention that to attempt to define social work is a fruitless task due to the competing values, ideals and intentions underpinning the perspectives with a vested interest in conceptualising it. Critically, conceptualising a professional framework for social work positions rather than defines the role, and such conceptualisations have been suggested to be a "time-wasting diversion" (Evetts, 2013).

Professional conceptualisations of social work are therefore difficult to articulate. As illustrated in the discussion above, theoretical conceptualisations of professional identity go beyond the internal perception, requiring external validation to be fully realised (Wolfensberger, 2011b). Similarly, frameworks for professionalism are built around how a role is enacted, rather than what the role is (Weiss-Gal and Welbourne, 2008). For social work, a profession developed organically to fill the gaps left around other professions (Wiles and Vicary, 2019), drawing on a cross-disciplinary knowledge base informed by tacit practice knowledge (Webber, 2013) and positioned firmly within the statutory frameworks of practice (McLaughlin, 2010), establishing this clear role to enable an autonomous

professional identity continues to prove elusive, a challenge echoed across the global stage (Wiles and Vicary, 2019; Ornellas et al, 2018; Weiss-Gal and Welbourne, 2008)

## 2.3 Beyond social work: professional identity in allied health professionals and the multidisciplinary context

Research into professional identity is either generically theoretical or heavily uni-professional and, in turn, draws on literature relating to the particular profession under investigation to inform the discussion. In this context, perceptions of and dilemmas relating to professional identity become viewed as specific to given professions, accompanied by a presumption and perception that other professions hold more clearly defined roles (Terry, 2019; Hughes, 2001). However, this presumption deserves scrutiny, as learning from the conceptualisation challenges faced by other professions may enable social work to address those challenges within itself.

Research across the allied health professions highlights that social work dilemmas of professional identity and ambiguity over role are not unique. Occupational therapists, (Grant, 2013; Hughes, 2001), therapists (Gent, 2017) and pharmacists (Elvey et al, 2013) have all spoken in similar language to social work about occupying positions on the periphery of practice and operating with poorly defined and enacted professional identities. Nurses, like social workers, conceived themselves as working within liminal spaces, with nurses identifying that they operate across boundaries, adopting an increasingly generalist role and undertake the 'dirty work' rejected by other professionals (Terry, 2019; Morriss, 2016b). Similar to social work, nursing identifies itself as being overly burdened by administrative tasks due to a weak professional identity and raises concern around its core tasks becoming increasingly deprofessionalised and re-routed to unqualified staff (Bailey and Liyanage, 2012; Harmer, 2010). The status differential so central to social work identity discussion is also an area of concern for nursing (McCrae et al, 2014).

Indeed, the parallels between nursing and social work do not stop at concerns around poor role definition. Consider, for example, the following definition:

"*qualified… staff enacting a widely-competent flexible application of personal professionalism in response to service users everyday needs.*"

(Hurley, 2009)

While this would not look out of place in any text on social work professional practice, this definition was proposed by mental health nurses following a study in which they positioned the key professional characteristics of mental health nursing as follows:

- Generic specialist
- Service user focused
- Positioning and utilising the personal self
- Spending time with service users
- Delivering talk-based therapy in versatile ways
- Having an everyday attitude
- Having transferrable skills

(Hurley, 2009)

Again, these descriptors would not appear out of place in a discussion about social work practice. Social work and nursing roles do have some overlap in the multidisciplinary environment (Terry, 2019); however, discussions around nursing focus on service user care and operating despite the boundaries of policy (Grant, 2013) and stealing roles from other professions (Crawford et al, 2008) in a manner reminiscent of similar discussions within the social work context. This raises questions about the extent to which professional diversity among the allied health professions within multidisciplinary teams truly exists.

Indeed, Brown et al (2000, p. 426) identified concern around "creeping genericism" as a prevailing feature of multidisciplinary teams, reflecting the shifting policy direction of the early twenty-first century. This posits that the co-operative work environment, characterised by increasingly blurred roles due to the growing pressures of knowledge interchange and workload and informed by policy emphasising generic service provision, erodes distinctive professional identities and leaves professionals isolated and increasingly similar across groups. Tellingly, their research within a mental health context identified

occupational therapists, nurses and social workers – the professional groups most likely to hold the generic role of care coordinator – as most at risk of this experience of professional attrition. Erosion and blurring arguably becomes role synthesis, with professionals employed to undertake similar roles within a team, adopting and internalising a shared role and sense of identity, which they in turn attribute to their particular professional status, acknowledging the discomfort that professionals have with hybrid roles (Workman and Pickard, 2008). Correspondingly, narratives around the difficulties in articulating professional identity acquire a degree of homogeneity which crosses professional boundaries.

As previously established, however, professional identity is not purely an internal phenomenon. The external perceptions of other professionals form a critical part of identity formation, and communication and interaction with other professionals is essential to ensure that a shared and agreed professional identity is established and enacted (King and Ross, 2004). Successful professional identity necessitates both validation from, and meeting the expectations of, the external observer. It is perhaps then concerning that, repeatedly, research with professionals shows them constructing narratives of other professionals which are either critical or flatly hostile (Best and Williams, 2019; Joynes, 2018; King and Ross; 2004). This raises potential for tensions between internal and external perceptions which undermine professional agency and effectiveness (Murray, 2013), with disparity in the valued image impacting correspondingly on perceptions of competence (Osburn, 2006).

In this context, debate about whether professional identity offers a useful contribution to the multidisciplinary environment becomes relevant. Grant (2013) highlights that operation within a multidisciplinary team has the potential to erode professional identity, especially where a profession is underrepresented within the workforce of that team. However, clearly defined roles in these contexts have been argued to be a legacy of nineteenth century institutionalisation and to hold no place in more modern, community-based services. Indeed, policy reviews through the end of the twentieth century around healthcare provision suggested a shift from prioritising distinct roles to eradicating the same (Hughes, 2001), with a move toward a more generic provision of services. Professional identities have been identified as a barrier to effective multidisciplinary working, with

professions becoming siloed into set and restrictive ways of working, reducing the flexibility so valued in professional autonomy (Elston and Holloway, 2001). Such silos in turn impact on effective communication within teams and have been associated with failings in client care (Joynes, 2018), where, by contrast, a more flexible and open approach to professional identity reflects a more open and adaptable approach to change overall (King and Ross, 2004).

Brown et al (2000) highlight pre-existing professional roles and affiliations as a barrier to fully committed membership of a multidisciplinary team, suggesting the professionals can hold only a limited number of allegiances. In line with an approach predicated in social identity theory (Tajfel and Turner, 2004), affiliations would therefore become weaker in relation to the aspect of professional identity the practitioner deemed less important. Priorities within how the role is perceived then in turn influences how professionals will react to threats to their role identity. With professional roles developed through a process of shared and exchanged perspectives and understandings, the potential for role ambiguity becomes high (Hunter and Segrott, 2006).

By contrast, however, it has also been argued that integration which dilutes professional diversity also dilutes the quality of the service received by clients (Lilo, 2016) and minimises distinct contributions from a range of different perspectives (Coppock and Dunn, 2010). Working within education, Gaskell and Leadbetter (2009) highlight that professional diversity contributes to positive working environments within integrated settings, by fostering a workforce with a positive sense of self (Best and Williams, 2019). Clearly defined boundaries within a professional team have, in turn, been shown to reinforce individual, psychological perceptions of self (Brown et al, 2000) and to increase the opportunity for collaboration (Sheppard, 1992), with the uncertainty caused by role ambiguity minimising this as practitioners struggle to identify their contribution within a team (King and Ross, 2004). Indeed, professional identity has been identified as a critical component in achieving practice changes within health and social care environments (Best and Williams, 2019) and genuinely multidisciplinary perspectives arguably offer a greater benefit than the perceived sum of the combined professional contributions (Bailey and Liyanage, 2012).

Concerns around silo working have been suggested to arise not from the existence of multidisciplinary approaches, but instead as associated with professionals attempting to publicly defend their role (Hannigan and Allen, 2011). When considering the drivers for this type of defensive practice, it is important to consider that the blurring of roles and the expansion of practice by one particular group of professionals inevitably represents a corresponding role erosion for a second group within the same multidisciplinary setting (Hughes, 2001). Role clarity in this context becomes critical; it is arguably not the presence of multiple professional perspectives which promotes practice defensiveness, but rather the ambiguity around how these perspectives interact and complement one another in the practice setting.

Indeed, setting appears critical in the conceptualisation of professional role across the health and social care professions, with physical, organisational and political contexts all influential in the role definition and clarity. Evetts (2013) suggests that distinguishing between the individual profession versus the individual occupation is a misdirection of focus, drawing instead on concepts of organisational professionalism, where professional status is rooted in organisations rather than within individual practitioners. In this context, professional activity is normalised within an organisational framework as a collective of practitioners (Egener et al, 2012). The exercise of authority is standardised within a rational-legal framework dominated by managerialism, hierarchical decision-making and target led accountability (Evetts, 2013). Organisational professionalism therefore downplays the focus on the individual interaction with the client, in favour of an emphasis on the bureaucratic structure which underpins the organisation (Fenton, 2016). The creeping influence of organisational professionalism within health and social care systems (Fenton, 2016; Egener et al, 2012) has not gone unnoticed, with Brown et al's (2000, p. 426) "creeping genericism" perhaps explained by an increasing willingness for the structures of state to imbue authority not in the individual professional, but in the professional organisation (Evetts, 2013).

Clearly, therefore there are arguments to both emphasise and downplay the variety of professional identities in scope within a multidisciplinary setting. While there is overlap between professionals in these contexts, both in terms of perception and enactment of role

(Sims, 2011), the continued contribution of team members from ostensibly differing professional backgrounds suggests that the complex interplay of ideas requires a process of negotiation and construction to develop a shared and representative understanding of each participants' skills and potential contribution. While principles of professional organisations present a direct challenge and counter to the concept of the individual professional (Evetts, 2013), challenges to professional identity are not accepted without contest (Hannigan and Allen, 2011). Alternatively, professional identities could potentially be negotiated to build a cohesive organisational identity which in turn makes most effective and efficient use of the skills available to it (Best and Williams, 2019). In order to achieve this, however, a clearer understanding of the distinctive contribution of each of the professional roles within this multidisciplinary setting is essential. Professional integration needs to be shaped and managed; evidence to date suggests that it cannot be left to chance (Best and Williams, 2019; King and Ross, 2004).

## 2.4 The holistic lens: professional identity in the wider context

A final consideration for this discussion relates to the impact of the wider social and political context on the development and articulation of professional identity. Models of austerity have shaped practice in health and social care for over a decade, with a corresponding impact on funding, staffing figures and role expectations (Terry, 2019; Ferguson and Lavalette, 2013). Despite governmental claims and media proclamations that austerity has come to an end (Giles, 2019; Jordan, 2019) the lasting effects of austerity manifest as a poor commitment to welfare which impinges on the capacity for the state to repair the damage done to welfare structures throughout the last decade, societal scarring in the form of reduced access to resources and assets and a 'race to the bottom' in terms of the economic structures which support the rectification of this (Irving, 2021). Subsequent crises in terms of the UK's exit from the European Union and the coronavirus pandemic have similarly presented as threats to the systems of social welfare in preference of prioritising corporate welfare (Farnsworth, 2021).

In this context, professional autonomy is arguably a benefit, as it grants professionals the freedom and discretion to apply resources in the most appropriate ways for the client group

they are faced with (Grant, 2013). However, this presumes that, in the context of organisational professionalism (Evetts, 2013) and beset by targets, efficiency and financial accountability, professionals are indeed granted this autonomy in the face of "the encroaching demands of the state" (Fitzgerald, 2014). In the context of increasingly centralised state power and control (Farnsworth, 2021) the likelihood that professionals will be allowed the time to enact their professional roles effectively, rather than seeing a lack of resources translated into a lack of dedicated time for specific professional roles (Adams, 2013) seems low. This correlates with Gaskell and Leadbetter's (2009) observation that changes in practice can be most easily incorporated into professional identity if they are undertaken through choice rather than enforced.

This last point is particularly pertinent when considered in the context of the increasing standardisation and regulation of care and care provision. Linked to earlier discussion framing social workers as agents of social control, Hunter and Segrott (2006), in their work around clinical pathways, highlight how standardisation of care reshapes professional roles and undermines professional ideologies, replacing expertise with inflexible procedures and removing the discretionary space needed for the exercise of professional autonomy and judgement. The professional context in itself becomes restrictive, and this is a particular issue for social work, which is perceived already by health allied colleagues as over-bureaucratised and restricted (Workman and Pickard, 2008). Dual restriction undermines professional identity, and confidence in professional competence. Professionalism in the context of a regulatory and regulated regime therefore can become negatively reinforced (McCrae et al, 2014) with the associated risk of professional disassociation, defensive practice and a distancing from professional roles.

Fook (2012) suggests that the technocratisation of social work represents a broader political agenda to economise the provision of welfare, moving away from a state funded provision to a more measurable, marketable provision, reflecting Farnsworth's (2021) postulation that the contemporary state prioritises corporate over welfare wellbeing. In terms of a more general social work identity, this approach is likely to result in the fragmentation and sense of poor fit experienced by Wiles and Vicary's (2019) participants in their attempts to articulate an overall professional description. Remembering that social work is ultimately a

political construct (Thompson, 2009), the impact of the enactment of political ideologies, especially where these have moved toward the right (Farnsworth, 2021) can be anticipated to have a direct and notable effect on how professional identity is understood and interpreted, both from within and externally to the profession (Ferguson and Lavalette, 2013).

The other key contextual consideration for professional identity is in the relevance and influence of the workplace environment, beyond the specific characteristics of the integrated team. Roles within teams can vary by region and nation (Terry, 2019; Wiles and Vicary, 2019) and the demands of specific workplace settings can vary (Wiles, 2017a). Work structures and professionals are arguably interdependent (Adams, 2013), with each shaping and influencing the other. Wiles (2017, p. 355) suggests the workplace operates as a "community of practice", which generates and normalises meaning and aspects of identity. With this consideration, the propensity for social work to operate across professional boundaries is worthy of note, as cross-agency and cross-organisational working has the potential to pose specific identity challenges which may contribute to social workers' experience of role ambiguity and difficulties in defining their roles, especially where organisational priorities might differ (Workman and Pickard, 2008; Brown et al, 2000). Debates about the significance of organisational context and the multidisciplinary environment on professional identity explored in this chapter may have specific relevance for social work in mental health.

## 2.5 Conclusions

This chapter has explored the conceptualisation of professional identity as an abstract concept both for social work and for other mental health professionals, as well as considering the impact of the broader social and policy context. This conceptualisation is not without difficulty. The challenges in defining professionalism conceptually transfer to the considerations of the specific social work and the broader mental health workforces. A range of conflicting paradigms, from the constrained statutory to the holistic aspirational (Higgins et al, 2016), and incorporating tasks, knowledge, values and practice context compete for dominance in defining social work, while role blurring and crossover has

engendered a sense of professional defensiveness and siloing within mental health. Compounding this difficulty, it has been argued that political ideologies in the context of widespread social crises have contributed to practice environments which constrict the enaction of professional autonomy and the establishing of professional distinctiveness. Professionals in this field are therefore constrained by definitional ambiguity, jurisdictional defensiveness and restrictive practice environments. In an effort to provide clarity, and to further the argument proposed at the start of this chapter, it is critical to explore these elements not in isolation, but at their intersectional points. Considering the cross-organisational, multidisciplinary nature of the majority of mental health social work, it is appropriate that the focus should now be directed to the issue of social work professional identity specifically within a mental health context to establish how these competing demands and constraints come together to inform a professional status.

# Chapter 3 - Not who, but where: Professional social work in mental health contexts

Professional identity has thus far been established as amorphous, subject to debate and heavily influenced by context and perspective. If context and the external gaze are critical in defining professional identity and establishing role clarity, then understanding social work in practice cannot effectively be achieved outside of the operational setting, the complexity of which cannot be understated. Social workers in mental health often operate within a unique, cross-agency position, with working practices which can include multi- and uni-disciplinary working environments across both health and social care (see, for example, Lilo, 2016; Moriarty et al, 2015; Evans et al, 2012). Further to this, these working environments are not provided as a homogenous whole. Within mental health services unique provision is offered both to young people and older adults, while within the 'general' mental health services provided for adults, provision includes both generalist Community Mental Health Teams and specialist Early Intervention, Crisis Resolution and Assertive Outreach services, although this latter has been largely phased out over the last decade (King's Fund, 2015). To talk about 'mental health services' as a whole incorporates a range of services tailored to the characteristics of specific groups, and, to an extent, research has often therefore focused on particular services, with studies drawing specifically, for example, on older adults settings (Verbeek et al, 2018; Wilberforce et al, 2015) or the impact of service structure on the transition from children's to adults services (Belling et al, 2014; McLaren et al, 2013).

This variation in positioning of mental health social workers within the context of different services has relevance. Satisfaction within a job, and subsequent successful work performance are intrinsically linked to three aspects of employment; the individual as worker, the work role and the organisational context (MacAteer et al, 2016) or, to match with the conceptualisations within this thesis, the professional individual, the professional role and the practice context. Critical to understanding mental health social work is a comprehension of these three elements both independently and interactionally. This chapter, in addition to considering the professional role of mental health social work in its own right, and as distinct from the social work role more generically, will also explore the

concepts underpinning the role specifically within the mental health setting, alongside the direct influence of that setting itself.

## 3.1 Standing on the edge: social workers in mental health

As with wider ideas of professional identity, defining the role that social work plays within mental health has proven characteristically challenging. It has proven to be both unclear (Allen, 2014) and difficult to articulate (Woodbridge-Dodd, 2017) and even where articulation has taken place within the literature, this has struggled to filter to the reality of frontline practice (Tucker and Webber, 2021), leading to widespread misunderstanding and variation in perspectives on the profession. Boland et al (2019) highlight a mismatch between academic expressions of mental health social work, linked to social perspectives and interventions, and client experience of social work in mental health. However, this confusion is perhaps integral to the nature of social work. Social work exists simultaneously as a traditional academic discipline and as a profession, but the former is a more recent development, as evidenced by the limited research base upon which it rests (Bailey and Liyanage, 2012). Consequently, social work has developed an epistemic identity rooted in practice over theory (Ekeland and Myklbust, 2022). Arguably, as previously discussed, social work as a field of practice is a more modern political construct (Thompson, 2009), rooted in statutory duties, with policymakers holding as much sway over its defining characteristics as academics or professionals themselves. Drawing on a traits approach to professional identity (Weiss-Gal and Welbourne, 2008), it is not surprising therefore that definitions of mental health social work vary widely, from the pragmatic, easily categorised to a more esoteric abstract. Each avenue claims to identify the distinctive element which social work adds to mental health work more widely, either in terms of *what* is done, *where* it is done or *how* it is done.

As with social work more widely, from the more pragmatic perspective, the social work contribution to mental health is defined in the context of practical tasks deemed specific to social work (Dwyer, 2005; Morgan, 2004). Within a highly medicalised hierarchy (Priebe et al, 2013), these tasks relate to areas of need held to be social in nature, such as employment (Akabas and Gates, 1999) or independent living (Beresford, 2005). Implicitly, such roles fall

outside the scope of health services, and into the remit of social work as the lone non-health professional within the mental health multidisciplinary scope. Evidence suggests that this social perspective and intervention is deemed an integral contribution in the frontline of practice (Abendstern et al, 2022), acknowledging that understanding and addressing the social determinants of mental health is essential to effectively address mental health issues (Karban, 2017) and social work is uniquely positioned to offer socially situated explanations of and approaches to so-called medical issues (McCrae et al, 2005). However, rather than suggesting a distinctive contribution, such positioning highlights the potential for social work to be perceived as the 'dirty work' (Morriss, 2016) of the mental health context; those tasks which need to be completed but are perceived as being of less intrinsic value than the principal work of the team. Similarly, despite evidence of frontline support, with dominant practice narratives built around risk and symptom management, these 'additional' tasks risk falling out of focus (Whitaker et al, 2021) within standardised and monitored professional contexts (Evetts, 2013). Rather than representing the professional contribution of social work, such tasks could instead position social work as marginal and marginalised within mental health, given responsibility for tasks seen as unwanted or unimportant rather than offering a more inclusive experience of care.

Mental health social work's access to specialist technical resources and legislative responsibility frames the second pragmatic definition. Social work has been argued to be a legislatively distinct profession (Lilo, 2016), to the extent that its statutory roles in terms of care management, safeguarding, mental capacity and mental health detention arguably shape the overall social work provision (Hannigan and Allen, 2011). Social workers have access to particular specialist knowledge around social care provision and statutory obligations which are not equally reflected in their health colleagues (Abendstern et al, 2016), while social work dominance within the Approved Mental Health Professional (AMHP) workforce provides an unparalleled understanding of the relevant mental health legislation.

Caution has been urged however against overemphasising the AMHP role. Karban (2017, p. 896) highlights a "legalistic overemphasis" on the AMHP prescribed statutory duties, at the expense of the social perspective informing decisions in the crisis context. More broadly, a

focus on this legally defined role risks ignoring the contribution of the wider social work mental health workforce who do not hold this specific role (Matthews, 2010). Campbell et al (2018) goes so far as to suggest that a legalistic focus leads to individual social workers in turn neglecting those areas of work which fall outside the statutory definition. Defining a profession in the context of a role not universally held represents a misunderstanding of the nature of the work that mental health social workers undertake, with AMHPs themselves drawing a distinction between their social work practice and their AMHP work as two markedly different entities (Buckland, 2016), with only one in four AMHPs operating exclusively as an AMHP (Skills for Care, 2021a). It has also been highlighted that such disproportionate emphasis places an expectation on mental health social workers to adopt this role in order to argue professional distinctiveness, to ensure that their wider contribution to mental health services is not disregarded and, in some circumstances, to maintain their employment (Lilo, 2016; Gregor, 2010).

Indeed, defining the social work role in this context through reference to local authority statutory duties (Lilo, 2016) is arguably flawed. This rests on the inherent assumption that social work and local authority work is indistinguishable and that social workers do not offer anything distinctive beyond acting as a representative of the organisation. However, this makes substantial and erroneous assumptions about the employment status and position of social work within voluntary and statutory services; while local authorities are a significant employer of social workers, they do not do so exclusively. Although care management functions feature heavily within technical lists of social work roles (see, for example, McCrae et al, 2004; Stanley and Manthorpe, 2001), it is not necessarily clearly understood outside adult social work, with some confusion around the distinctions between care management and the Care Programme Approach (McCrae et al, 2004). Mental health social workers themselves have drawn the distinction between social work duties, and local authority duties as enacted by social workers (Tucker and Webber, 2021), positioning statutory duties as a contextual rather than a professional obligation. Indeed, the execution of statutory duties is a highly contextualised activity, driven by local policies and priorities. The presumption that professional training equips social workers with the necessary bureaucratic knowledge to undertake such work or advise on such resources places social workers in a position where failure is a distinct possibility, with the associated shame of

professional shortcomings a substantial concern (Webb, 2015). Lack of understanding of bureaucratic systems which exist outside of the work role risk spoiling the image and perceived competence of mental health social work if work roles and professional role are conflated in this manner (Osburn, 2006).

Even where knowledge is sufficient, the bureaucratisation inherent in the care management approach has been well documented; the care manager role has been prioritised at the expense of professional decision making as an approach that can be used by qualified and unqualified staff if equipped with the appropriate skills in administration (Hatfield and Mohammad, 1996). However, driven by bureaucratic and standardised approaches to social care intervention (Postle, 2001), care management is less reliant on professional training, and more on the tacit practice knowledge gleaned through working within a specific social work context (Webber, 2013). In turn, this makes it a role accessible to any practitioner working in the field, regardless of professional status. Perhaps more importantly, however, it denies it to any mental health social worker without that relevant experience. Mental health social workers in services divorced from the local authority obligations under the Care Act, 2014, lack the process knowledge required to undertake a care manager's role. With legislatively framed roles, therefore, social work risks being defined by tasks for which it has neither the universal remit, nor the necessary expertise.

As with social work more widely, defining mental health social work in the context of tasks which are not inclusive of the full workforce, and which do not require social work specific skills to undertake would appear to provide a poor definition for mental health social work. Furthermore, social worker distaste for such proceduralised, bureaucratised roles has been demonstrated with a mindset which views mental health work as 'proper' social work, by contrast to the local authority equivalent (Abendstern et al, 2016). This raises the question, however, about what exactly qualifies as 'proper' social work and whether this might reflect the characteristics underpinning professional identity.

Abendstern et al's (2016) participants framed 'proper' social work in the context of long term, relationship focused and protective interventions. A relationship-based focus is central to social work narratives, and an emphasis on relationship building features strongly

in both academic and frontline discussions of the social work role in mental health (see, for example, Boland et al, 2019; McCusker and Jackson, 2016; Butler et al, 2007; Postle, 2001; Peck and Norman, 1999). This in turn dovetails with the expressed wishes of service users, who similarly place a high emphasis on relationship-based work (Wilberforce et al, 2020; Duggan et al, 2002). The relationship is posited as an aspect of a more broadly holistic and value-based approach (Peck and Norman, 1999) built around empowerment and person-centred care (Tucker and Webber, 2021; Wilberforce et al, 2020; Butler et al, 2007) or as an alternative to the legislative framework within which to position other social work tasks such as assessment (Murphy et al, 2013). This perspective prioritises the relationship as the primary intervention (McCusker and Jackson, 2016) and positions social work as essentially non-neutral in the context of service user needs and vulnerabilities (Boland et al, 2019).

By contrast to the tasks and duties-based approaches, which focus on *what* mental health social work does as a vehicle for categorisation, with an emphasis on relationships, empowerment and promoting service user needs centres the search for distinctiveness on *how* mental health social work is undertaken. Such an approach provides a welcome contrast to the medical hegemony (Lilo, 2016); however, in turn it also acts as an implicit challenge to the medical hierarchy through adoption of an approach based on conflicting professional assumptions (Whitaker et al, 2021; Sheppard, 1992). Goemans (2012) argues that mental health social work should maximise this approach to adopt a truly social perspective, rejecting diagnostic interpretations of experience. However, as highlighted in the previous discussions of social role valorization (Wolfensberger, 2011a), for social work to establish its professional competence on this basis, it is necessary to offer a robust defence of the stance, and values-based approaches are notoriously difficult to define, let alone defend. Agreeing universal values is challenging (Buckland, 2016) and can lead to inter-professional confusion in terms of role validation (Peck and Norman, 1999) which, as previously discussed are inadequately addressed through the vagaries of either the *Code of Ethics* (BASW, 2021) or the *Professional Capabilities Framework* (BASW, 2022).

Social work's position within mental health poses a similar challenge to defending its role. Lilo (2016) has argued that social work needs to be embedded within mental health settings in order to exert influence on organisational cultures and approaches, however, it has been

suggested that even where embedded within organisations, social work lacks professional parity and risks being subsumed within a health culture (McCusker and Jackson, 2016), relegated to the role of "professional eunuch" (Morriss, 2015). In support of this framing, Gregor (2010) suggests that mental health social work is both marginalised and diminished, existing as an isolated minority with responsibility and autonomy being eroded (Moriarty et al, 2015; Beresford, 2005).

It is, however, from precisely this fragile positioning that Nathan and Webber (2010) propose that social work enacts its distinct mental health contribution. In order to counter the medical hegemony, they argue that social work should be marginalised in order to better straddle boundaries and work both with healthcare and with service users. A disempowered perspective enables social workers to engage more effectively with service users and minimises the potential for integration with health to the extent that professional perspective is lost. In this way, this perspective argues that it is *where* mental health social workers practice that frames their distinctive identity within the medical framework of mental health.

The perception of social workers operating on the edges of practice has received some considerable support. Mental health social workers in particular are argued to be ideally positioned to bridge the divide between services, aided by their contrasting educational and practice experiences (Evans et al, 2005; Stanley and Manthorpe, 2001). Historically, this manner of boundary work was indicative of mental health social work intervention and Carey (2015) argues that managing such fragmentation and working within 'messy' contexts is a core element of the social work role. The dual perspective of *where* social work operates enables social workers to promote an independent perspective as an alternative to dominant medical perspectives (Cree et al, 2015), a contribution seemingly valued by frontline health colleagues (Abendstern et al, 2021).

Acknowledging that mental health social workers have a history of innovative and autonomous practice within their marginalised position, Ramon (2009) argues that this has been partnered with a tendency toward compliance and adopting a challenging position has not been a consistent approach within the profession. Defining a profession on the basis of

a unique contribution it *could* make rather than one it consistently does risks isolating those practitioners who do not, or cannot, easily adopt such an assertive approach, especially when operating in isolation as is relatively common in this context (Moriarty et al, 2015). A further complication arises in the presumed positioning of mental health social workers within health services; Lilo (2016) identified that only 55% of local authorities surveyed in their study had a formal partnership agreement in place with their respective health trust which would allow for the sharing of staff in this way. Similarly, recent reports have suggested that local authorities have moved away from integration in favour of ensuring their core statutory duties are met (Abendstern et al, 2022; Tucker and Webber, 2021; McNicholl, 2016). This suggests a potentially substantial number of mental health social workers do not work within the health setting and may never have done so. While Nathan and Webber's (2010) argument holds weight as a practice approach, its specificity of positioning renders it too exclusive for use as a broader role definition that captures all permutations of mental health social work.

Lack of clarity around role and professional identity has arguably had a detrimental effect for mental health social workers. Compounded by a resoundingly negative portrayal of social work in the media sphere (Morriss, 2016a; Collins, 2015; Murphy et al, 2013) fuelling a fouled perception of social workers, especially in contrast to 'nursing angels' (Kotera et al, 2019), social work experiences a poor public image both generally and within mental health (Wain, 2016; Duggan et al, 2002) which in turn impacts on the relationship between social worker and service user (Bailey and Liyanage, 2012). Additional reports of a sense of abandonment, specifically for those local authority social workers working within health settings (Phillipowsky, 2018; Bailey and Liyanage, 2012), demonstrate how a lack of role clarity and professional identity has contributed to a profession in emotional crisis.

Studies into workforce morale and role identity within mental health consistently show social work performing poorly in the context of practitioner wellbeing. Mental health social workers have repeatedly been reported as experiencing poor job satisfaction and high emotional stress (Coyle et al, 2005), especially for those social workers operating across agencies (Reid et al, 1999). Social workers perform poorly in comparison to other mental health professionals (Priebe et al, 2005), with role stress and role confusion a recurring

theme (MacAteer et al, 2016; Mitchell and Patience, 2002). In one study, social workers reported confidence in their skills and performance (Mistral and Vellerman, 1997), but this study experienced a notably low response rate from the social work sample, and it is expected that this significantly impacted on the findings.

Kotera et al (2019) were able to link role issues as predictors for poor mental wellbeing among social workers, offering an explanation for why social workers have been found to be more preoccupied with role than other professionals (Priebe et al, 2005). This is perhaps understandable; without clear ideas of role, it becomes challenging to maintain a sense of self-efficacy and competence, threatening the value of the professional image (Osburn, 2006), which in turn predicts increasing stress and decreasing wellbeing (MacAteer et al, 2016). Additional clarity in understanding role therefore appears to be critical for the profession.

Guidance on social work practice is overwhelmingly generic. *The BASW Code of Ethics for Social Work* (BASW, 2021) establishes values and ethical principle to underpin the profession as a whole which, correspondingly to encompass the diverse scope of UK social work, are by necessity broad. The *Professional Standards* (Social Work England, 2019) in England and *The Social Worker* (Social Care Wales, 2019) set out similarly broad guidelines which necessitate interpretation into practice, opening the way to variations in understanding and application in the professional context. It is interesting, therefore, that a formal definition of mental health social work specifically in the English context has arisen from within the profession. *Social Work for Better Mental Health: a strategic statement* (hereafter *the Strategic Statement)* (Allen et al, 2016) incorporates the legal obligations which social workers enact on behalf of local authorities and the aims of the profession into an aspirational statement on the role of the mental health social worker. The *Strategic Statement* incorporates five key role categories:

1. Enabling citizens to access the statutory social care and social work services and advice to which they are entitled, discharging the legal duties and promoting the personalised social care ethos of the local authority
2. Promoting recovery and social inclusion with individuals and families

3. Intervening and showing professional leadership and skill in situations characterised by high levels of social, family and interpersonal complexity, risk and ambiguity
4. Working co-productively and innovatively with local communities to support community capacity, personal and family resilience, earlier intervention and active citizenship
5. Leading the Approved Mental Health Professional workforce

*Adapted from (Allen et al., 2016)*

Although not intended to be comprehensive (Allen, 2014), the *Strategic Statement* offers a unique operational definition, seeking to develop a distinct role beyond generic service broker, or generic mental health practitioner (All-Party Parliamentary Group on Social Work, 2016) and the sweeping statements of the *Professional Standards* (Social Work England, 2019). However, research indicates professional apathy in relation to these roles which were seen as failing to reflect the diverse realities of their practice, especially in relation to local authority obligations, community engagement and the AMHP role (Tucker and Webber, 2021). Instead, mental health social workers drew on values (Peck and Norman, 1999), holistic and person-centred practice from a boundary crossing perspective (Tucker and Webber, 2021) and professional challenge around social justice and conceptualisations of risk (Abendstern et al, 2021) as their distinctive contributions to mental health practice. Despite being rooted within the professional, the *Strategic Statement* appears to have gained less practice prominence than would have been hoped.

The social worker perspective in itself is perhaps significant at this point. Mental health social worker perspectives on their role are under-represented within empirical research, with a stronger focus on Community Psychiatric Nurses (see, for example Hannigan and Allen, 2013, p. 383; Crawford, Brown and Majomi, 2008) or on professional role comparisons (see, for example, Bressington, Wells and Graham, 2011; Beinecke and Huxley, 2009; Peck and Norman, 1999; Sheppard, 1992). Studies focused on social work have primarily examined the AMHP workforce (see, for example, Stone, 2019; Buckland, 2016; Morriss, 2016b; O'Hare et al., 2013; Gregor, 2010). However, some evidence does exist. Peck and Norman's (1999) study into professional perspectives on role saw social workers define themselves by perspective rather than by task, offering a value-based, culturally

situated definition of their contribution to the multidisciplinary team. This positioning focused on the *where* and *why* of practice, rather than the *what* and *how* (Tucker and Webber, 2021), in turn highlighting that the position of the social work role is significant, in addition to the content. It is perhaps telling of the challenge facing social work within mental health services, that this caused consternation with their medical colleagues, and a call for more clarity on the specific social work role within the multidisciplinary team.

Two further studies emphasised this attention to role in the context of positioning. Bailey and Liyanage (2012) explored the mental health social worker in light of the introduction of the generic care coordinator role. This study did identify a disconnect between the benefits of professional diversity and mental health genericism. Participants felt professional identity was significant to the extent that this was explored; however, the emphasis of the study was on the context of practice and mental health social workers' experience of both local authority abandonment and health service domination, which positioned them as disempowered, disadvantaged and under professional threat. While professional identity was clearly relevant, establishing a more general understanding of mental health social work professional identity fell beyond the scope of the research. Woodbridge-Dodd (2017) similarly focused on the *where,* using social worker discourse to construct six practice positions that mental health social workers could occupy within the restrictive discourses of mental health practice: Care coordinator; Service user champion and advocate; Therapist; Deliverer and knower of LA duties; Professional social worker; Approved Mental Health Professional. While these typologies demonstrate some correlation with the roles laid out in the *Strategic Statement* (Allen et al, 2016) this arguably demonstrates a resonance with tasks rather than professional role. Here, the typologies represent the stance from which mental health social workers undertake their work, and the author themselves cautioned against using these as an objective definition of role divorced from practice context (Woodbridge-Dodd, 2017).

Focusing more specifically on role, Tucker and Webber (2021) identified three key themes which participants felt comprised their unique contribution to mental health services; working across boundaries, working holistically and working to need. Social workers positioned themselves on the boundaries between services and on the interface between

the service user and the service, with mediation and compromise to achieve outcomes central to their work. This mirrored Peck and Norman's (1999) earlier findings which emphasised position and priorities over tasks and leant weight to Nathan and Webber's (2010) argument of this as mental health social work's most effective home, although Ramon's (2009) caution about compromise over challenge also remained significant. Nonetheless, service structure and position were demonstrated as a key influence on effective social work practice. As with Bailey and Liyanage's (2012) study, social workers were again fiercely protective of their professional identity and unique contribution, even where their role was primarily that of a generic care coordinator, and their emphasis on holistic and person-focused intervention suggested that they identified unique value in terms of *how* they enacted this role. These findings were echoed by Abendstern et al (2021) whose participants positioned their role as value-driven and socially rooted, relational and operating at the nexus between the service and the service user. While these studies cast some insight onto the professional role of mental health social work, each was notably small in scale, reflecting perspectives from limited contexts and suggesting that a wider exploration of the mental health social work role would be beneficial to explore whether these perceptions are replicated on a broader scale.

## 3.2 United or divided? Role identity in the mental health multidisciplinary setting

Mental health services have led the way in multidisciplinary working, with collaboration central to the underpinning mental health policies for the last fifty years (Shepperd, 1992) and an expectation that effective integration will lead to an improvement in service delivery and outcomes (Wilberforce et al, 2016; Reilly et al, 2003). However, although there is some evidence that CMHTs produce effective outcomes (Evans et al, 2012), overwhelmingly the evidence base over time for multidisciplinary care is lacking (Wilberforce et al, 2016; Rummery, 2009; Carpenter et al, 2003) and concerns have been expressed that CMHTs do not adequately provide for mental health needs (Hatfield and Mohammad, 1996).

A lack of evidence supporting the efficacy of CMHTs has, in turn, led to a lack of direction in workforce and team planning, evident over previous decades (Anderson et al, 2021; Mistral and Velleman, 1997). Evans et al (2012) found that historical precedent was the most

common determinant in deciding the composition of mental health services, with teams built around a health focus where multidisciplinarity was rarely a consideration. In a smaller scale study, Rea (2005) identified a lack of leadership within one trust as leading to local variation in team formation and development. Teams are predominantly formed pragmatically, atheoretically and without appropriate research (Evans et al, 2012; Burns and Lloyd, 2004), with poorly designed services then acting as a barrier to integration (Phillipowsky, 2018). Variation has become non-purposive in terms of maximising service delivery and instead exists by rote (Wilberforce et al, 2015). While policy focus may be on integration, organically developed teams tend to be medically dominated and task oriented, with a lack of clarity around roles (Gulliver et al, 2002) which are then required to be negotiated around murky boundaries, rather than defined subject positions (Hannigan and Allen, 2011). Carey (2015) suggests this is equally as likely to lead to confused interpretations as effective collaboration, with corresponding detrimental impact for those attempting to access services. With multidisciplinary teams constructed on a haphazard basis, and the evolving policy context currently unclear (NHS England, 2021; Welsh Government, 2020) the scope for professional identity within teams is broad, with the option to gravitate toward either a specialist or a generic model of working.

Considering first the generic approach, this fits more neatly with a task-oriented service. Mitchell and Patience (2002) highlight that no one professional discipline has the necessary skills and knowledge to provide a comprehensive service; however, where services are delivered by generic practitioners, work can be matched on an individual competency rather than role basis (Aiello and Mellor, 2019), theoretically resulting in a more seamlessly integrated workforce. Reilly et al (2003) found that integrated structures of care were more effective in delivering integrated services, while genericism built into the structure enabled a clear skills focus, without eliciting interprofessional conflict.

Generic approaches similarly acknowledge the substantial reported overlap in roles between social workers and CPNs (Crawford et al, 2008; Sheppard, 1992), which should in turn enable teams to respond more efficiently to need and to focus professional resources most effectively in achieving service goals around recovery (MacAteer et al, 2016) and minimising barriers to joint enterprise, which in turn promotes collective practice (Wiles,

2013). In the context of high financial demand on services (Kings Fund, 2015) and rapidly growing need (British Medical Association, 2020; Welsh Government, 2020; Mental Health Foundation, 2016) there is a strong argument to support minimising professional duplication and maximising effective service delivery.

However, genericism remains a contentious concept. Professional dilution in this manner is viewed with concern (Nathan and Webber, 2010), with claims that it results in less in-depth consideration of practice (Lilo, 2016) and provides a unilateral rather than multidisciplinary response to care, with the potential to disregard the wide range of skills and competencies available within any given team (Beinecke and Huxley, 2009). Social work in particular is likely to be disproportionately affected by a shift toward genericism (Boland et al, 2019, p. 3); with occupational roles in mental health predominantly health based (Beresford, 2005), it seems likely that social work's tacit knowledge would be subsumed beneath the medical-therapeutic hegemony (Webber, 2013), with more scientific and bureaucratic approaches given precedence (Ekeland and Myklebust, 2022; Duggan et al, 2002). McCrae et al (2004) suggest that such integration would erode professional skills, as social workers came under pressure to conform to a pragmatic agenda divorced from a moral base (Preston-Shoot, 2001) and lead to the loss of substantial social work expertise and experience without the corresponding reduction in social need.

Professional diversity with the multidisciplinary environment is not without its challenges, however. In the context of poor role setting and unclear task definitions, CMHTs have struggled with the role conflict and defensiveness which arises from role ambiguity and a lack of clarity (Belling et al, 2011), with a retreat to siloed cultures, professional inflexibility and competing for space and influence being a priority (Hannigan and Allen, 2013). Social work in this context, from its marginalised position, has the potential to react in a more extreme way than other professions, using professional identity as a form of internalised resistance against the pressures of the multidisciplinary environment (Webb, 2015).

Professional identities also provide ammunition for the defence of professional space, in the form of codes of conduct, professional expectations and legislative frameworks which impact detrimentally on effective multidisciplinary working (Rea, 2005). It has been

suggested by contrast that role ambiguity, and the associated distress that arises from it, can be countered by professional confidence (MacAteer et al, 2016), although it has equally been noted that role conflict can arise even where role clarity is strong, suggesting that the interprofessional tensions within CMHTs are not purely a defensive reaction to uncertainty (Carpenter et al, 2003).

Nonetheless, professional diversity can work to the benefit of service users, who have access to the broader range of skills and knowledge available when professionals retain their specialisms (Rummery, 2009), a position clearly recognised within the current practice reforms (NHS England, 2021; Welsh Government, 2020). A genuinely multidisciplinary approach allows for professional variability (Wilberforce et al, 2016) and results in challenges being addressed from a range of potentially complementary perspectives (Huxley et al, 2003). Bailey and Liyanage (2012) suggest that a multidisciplinary team can develop to become more than the sum of its parts, with collaborative working leading to solutions and ideas that no individual practitioner would have devised in isolation. Where this works effectively, professional identity remains relevant but becomes secondary to the wider team identity. In this context roles can be negotiated flexibly and confidently to accommodate new ways of joint working without erosion of the professional self (Gibb et al, 2009). Diversity generates more effective care than genericism, in the same way that stability generates more effective teamwork (Evans et al, 2012).

The perspective of frontline social workers on the generic-specialism debate has been under-explored to date; however, previous work does seem to suggest a lack of consensus upon where social work should sit within the multidisciplinary setting. McCrae et al (2004) identified three core typologies for mental health social work:

1. Genericist (‘mental health worker’)
2. Eclecticist (‘mental health social worker’)
3. Traditionalist (‘social worker’)

Interviewing social work practitioners, managers and academics, they identified an even split between those who favoured each approach, with no clear preference emerging. Whether this is indicative of a profession in the throes of an identity crisis or a profession in a state of flux moving from one identity to another is unclear. However, it reflects sharply

social work's inability to articulate its role with any cohesion across the profession and suggests a distinct need for further exploration of the interaction between social work identity and mental health identity for mental health social workers.

## 3.3 Movers and shakers: understanding the significance of context on mental health social work

The significance of context in social work practice is often acknowledged, but rarely explored. It is generally accepted that social work, as a constructed and socially situated profession (Sheldon and MacDonald, 2009), is heavily influenced by its context both environmentally and temporally (Gould 2010), in terms of its remit, its focus and its emphasis. Legislation and policy shape and inform social work practice, and social work cannot be considered in isolation of the social and political context within which it exists. However, such discussions generally focus on social work at the macro level, considering the context facing the profession as a whole.

Due to the localised and eclectic nature of mental health social work provision, the mental health workforce operates across a diverse range of environments and practice settings and within a range of organisations, influenced both on local and national policy levels at the frontline of practice. Employment arrangements vary by area and by team (Freeman and Peck, 2009), and informal reporting suggests a growing move away from integrated teams to more unilateral local authority provision (Boland et al, 2019; Lilo, 2016; McNicholl, 2016). This suggests that mental health social workers experience different influences on practice. Medical influences dominate within NHS settings (Beinecke and Huxley, 2009) while managerialism is perceived to be prominent in local authorities (Postle and Beresford, 2007). Although recovery-focused and strength-based approaches to practice dominate policy narratives around provision (NICE, 2021) statutory teams continue to be led by reactive social-control work (Whitaker et al, 2021) over innovative social inclusion practice which can rise to precedence in more voluntary services (Karban, 2017).

Webb (2015) suggests that identity is locked to organisational culture, reflecting narratives of organisational professionalism explored previously (Evetts, 2013). This represents a

significant point of consideration in mental health social work, where social workers might be local authority or NHS employees within their respective organisations and may also be employed by one organisation but situated in another. If identity is tied to organisation, and organisational settings vary so widely, this may articulate some of the difficulties experienced in developing an inclusive definition of professional role. Social work operates within organisation service frameworks, rather than with impunity. Where services run on a task-oriented basis (Murphy et al, 2013), or in line with service specific, and potentially conflicting, performance indicators (Lilo, 2016), rather than being informed by specific professional remits, then where those tasks and responsibilities vary across organisations, so too will the social work role as the nature of the workplace shapes the work to be undertaken (Hannigan and Allen, 2011).

Indeed, Davies (2021) argues that in the context of restrictive practice realities, innovative change – a curative model of social work – is an unachieved and unachievable goal. Rather, he proposes that change should be driven by the client's desire, and that instead the social work role is to support individuals to maintain their social role, and in turn to maintain a state of social equilibrium (Howe, 2014). Davies (2016) posits this approach not as a social work ideology or aspiration, but rather as a reflection of the reality within which social work finds itself. Critically, this maintenance theory expands the usual narrative of the client-worker relationship to a perhaps more realistic client-worker-organisation model (Davies, 2016). In the context of standardised, hierarchical and managerial service structures (Evetts, 2013), maintenance theory perhaps best reflects the interplay of power between the mental health social worker, the client, and the workplace context in positing the organisational context as an influential factor in the helping relationship.

This positioning reflects narratives around the role of the organisation in professional identity. Ashforth and Mael (1985), in exploring social identity theory in the context of organisational settings posited a heavily interactional framework for identity, with this both internally and externally defined. In their model, self-definition occurred in the context of identification within a distinctive ingroup, but this was positioned within a model of external prestige, measuring the respect and recognition afforded by other professionals and outgroup differentiation, wherein professionals defined themselves in terms of their

differences from other professional groups. Within local authority contexts, where social workers might be the homogenous professional workforce, such contextual influences are likely to be substantially different to the multidisciplinary and integrated health environments. Webb (2017) suggests that the workplace offers a source of professional socialisation, wherein the norms of the job are learnt in training (socialisation for work) and perpetuated in practice (socialisation by work). Professional normalisation therefore becomes highly sensitive to the perspectives and expectations of the outgroup as well as the ingroup, where these two elements coexist to inform professional role.

If these depictions of organisational context as directly influential on practice interactions holds true, then further contextual variation can be expected in the context of service structures heavily influenced by the impacts of austerity and budgetary reductions with public services. The Kings Fund (2015) identified that, despite real-terms reductions in funding due to the impact of austerity and increasing levels of demand for services, most mental health trusts were able to return a surplus in their annual budgets. They argued that this has arisen from a transformation of services away from evidence-based specialist models of practice to a more generic provision underpinned by changes in funding models, which in turn influences the social work role within those settings. While ostensibly this makes mental health services more sustainable, it is argued that this manner of restructuring represents a "leap in the dark" (Kings Fund, 2015, p. 17) due to the lack of evidence to support the effectiveness of this type of approach, with the result that the new structure fails to address the demands of mental health need, placing the system under pressure and reducing the overall quality of support offered to those in need, while also introducing role ambiguity and confusion for the staff working within those settings.

Cummins (2018) argues that in a service area disproportionately affected by austerity, the anticipated high costs of providing mental health care for an ageing population (Rummery, 2009) means that the innovative and holistic ideals of policy by necessity require a conventional and rote response. With services expected to do more with less, and with substantially increasing demand for support (British Medical Association, 2020) the space for non-essential intervention is small. In services dominated by a biomedical focus under a legislative framework which prioritises compulsion (Wilson and Daly, 2007), there is little

room for professional diversity and person-centred responses, regardless of the extent to which this is valued across the professional spectrum (Abendstern et al, 2021).

Although integrated care should, by its nature, offer diverse perspectives to ensure a holistic approach (Aiello and Mellor, 2019; NHS England, 2019a) the conflicting aims of reducing costs and working innovatively cannot necessarily co-exist (Rummery, 2009), with the result that intervention becomes homogenised to service regardless of professional diversity and individual need (Huxley et al, 2003). Critical to this understanding is a consideration of the move toward financially rooted planning for services and a focus on outcomes informed by tariff-based payment systems (King's Fund, 2015). A focus on outcomes is argued to come at the expense of professional expertise and diversity (McDonald et al, 2008), although Huxley et al (2003) suggest that professional training and expertise will influence decision-making, regardless of the integrative effect of social learning (Gibb et al, 2002).

Although, as previously discussed, austerity has now been decreed defunct (Giles, 2019; Jordan, 2019), the lasting effects (Irving, 2021) and the compounding effects of the coronavirus pandemic in particular (Farnsworth, 2021) have particular significance for the mental health practice context. Although the coronavirus pandemic initially saw a 40% drop in service demand (NHS Confederation, 2020), early indications are of an overall increase in psychological distress in the population (Pieh et al, 2021; Pierce et al, 2020) with future need predicted to increase across adults and young people, with an anticipated 8.5 million adults and 1.5 million young people requiring new or additional mental health support arising from the pandemic (O'Shea, 2020).

The anticipated need is expected to include a strong social work element, arising from prolonged isolation, family change and bereavement, and loss of employment and financial security (O'Shea, 2020). Compounding this, the current cost of living crisis is anticipated to have a substantial negative impact on mental health and wellbeing in the population (Anderson and Reeves, 2022), with social interventions again expected to be an essential element of the approach to resolution (Christodoulou and Christodoulou, 2013). Effective use of the mental health workforce in this context is critical. While demand for services is increasing, service provision appears to remain static while entrants to social work are

reducing, although qualification from specialist mental health programmes remains stable (Skills for Care, 2021b). Despite commitments to increase the mental health workforce to meet the aspirations of the Five Year Forward View for Mental Health (Health Education England, 2017) and the *Together for Mental Wellbeing* service reforms (Welsh Government, 2020), NHS staffing has remained stagnant or decreased over the last decade (British Medical Association, 2020). Increasing demand, stagnant provision and a directionless structure (Evans et al, 2012) indicate the need for professional role clarity in mental health contexts, regardless of whether this follows a professional or generic route.

In this context, it is perhaps unsurprising that there remains a lack of clarity around the social work role. With an unclear rationale for inclusion within an integrated mental health service, and local authorities likewise feeling the increasing pressure of restricted budgets and anticipated spending increases (Davies, 2021; Rocks et al, 2021; Watt and Roberts, 2016), concerns about a tendency toward the withdrawal of the seconded social work workforce in order to meet the core responsibilities of the local authority are perhaps to be expected (McNicholl, 2016). Indeed, the impact of local authority budget cuts are already reported to influence NHS services (King's Fund, 2015), with no clear rationale to maintain social workers within NHS settings. However, it is equally unclear as to whether this is the most effective and efficient way to deliver services and how these varying contexts of practice influence the role perspectives of the social workers working within them.

This discussion has highlighted strong disparities both in academic and practice understandings of the mental health social work role, as well as how this might be influenced in the context of multidisciplinary practice and across the varying settings of care in which social workers operate. Key to this has been the demonstration of a lack of clarity across all domains of mental health social work as to what shared consensus, if any, exists in relation to the role.

The nuanced and varied nature of the social work role necessitates that understanding is not imposed from above or delivered blindly through national policies; previous explorations of the mental health social work workforce suggest that 'top-down' explanations which clash with internal professional modelling will be rejected (Tucker and

Webber, 2021). It is critical therefore that, to better understand the mental health social work role, understanding is drawn from, and owned by, mental health social workers themselves. Similarly, with consideration for the potential wide variations in practice arising from contextual factors, it is similarly critical that any definition of the role attempts to synthesise similarities in perspective, while acknowledging the differences, to ensure that any professional definition of mental health social work is one that frontline practitioners are able to engage with and use to understand their practice with increased confidence regardless of context.

## 3.4 Mental health social work: the case for research

Mental health social work operates across health and social care landscapes, in the scope of increasing levels of need (British Medical Association, 2020; Welsh Government, 2019; Mental Health Foundation, 2016), which have not seen a corresponding increase in provision (British Medical Association, 2020). The effectiveness of the mental health workforce in this context is critical. However, the complex narratives of an ill-defined and multifaceted professional history (Burnham, 2011), combined with the ambiguity of social work professional identity as a whole (Wiles, 2017b) poses substantial challenges in understanding the position that social work is intended to occupy within mental health provision and suggests that deployment of this workforce could be less than optimal in meeting mental health need.

While efforts have been made in recent years to establish a clearer focus on mental health social work as a distinct contributor in mental health (HM Government, 2017; Allen et al, 2016), these perspectives have struggled to gain prominence in frontline social work practice (Tucker and Webber, 2021). In part, such externally imposed perspectives may trigger an element of "jurisdictional defensiveness" (Hannigan and Allen, 2011, p.6) from social workers keen to exercise the professional autonomy often deemed lacking in social work (Weiss-Gal and Welbourne, 2008). However, the influence of organisational setting and structures on professional role and identity (Ashforth et al, 2008; Ashforth and Mael, 1989) also suggest that considering mental health social work as a homogeneous entity may fail to reflect the realities of frontline practice (Tucker and Webber, 2021).

This research aimed to address this disconnect by establishing a profession-led definition of the mental health social work profession role which was adaptable across practice contexts. Through use of a national survey of social workers in England and Wales, administered online to ensure maximum accessibility, and a series of semi-structured interviews with a purposively selected sub-sample of survey participants, the research sought to explore participants' views on professional identity and role, the contextual factors that influence this and their interaction with the organisational context. This exploration aimed to address the following two questions:

1. How do mental health social workers understand their role within mental health services?
2. How does employment circumstances and context impact on mental health social workers' perception and undertaking of their role?

In order to maximise the relevance of the findings to the profession, the research design called for an inclusive coverage of mental health settings, which aimed to capture and represent the range of contexts within which mental health social work was practised. It also necessitated an understanding of the scope of the mental health social work workforce, in order to establish the extent to which the volume and variation in practitioners had been represented (Silverman, 1998). However, preliminary discussions during the research design stage identified a substantial shortfall in understanding of the provision of mental health social work in England (Trewin, 2019) and a paucity of data available for Wales. This necessitated a preliminary investigation of the mental health context, therefore, in order to provide a framework within which the principal stage of the enquiry could be undertaken. This investigation aimed to meet the following two aims:

- To establish a more robust estimate of the number of mental health social workers currently employed in England and Wales
- To establish where this social work provision is positioned within NHS and local authority settings.

To this end, information gathering was undertaken with all NHS trusts and Local Health Boards with responsibility for mental health provision, and all local authorities with responsibility for social care provision across England and Wales. Due to the foundational nature of this exercise in informing the remaining aspects of the research, in particular the recruitment of social workers for the later stages, this thesis will first report on the methodology and findings for this initial exploratory survey, in order to be able to subsequently demonstrate how these influenced the later stages of the research.

# Chapter 4 - Methodology: Establishing a preliminary understanding of the structure of mental health social work provision.

Undertaking research within public organisations necessitates a consideration of the impact of these in the context of limited and sometimes strained public resources (Farnsworth, 2021). While establishing a framework of mental health social work provision was deemed critical for the effective enactment of later stages of this research, there was also an awareness of the need to ensure that the impact of this was minimal in terms of the resource demand on local authorities and NHS trusts, while also producing robust and viable information that justified the request. This chapter seeks to explore this conflict, outlining the intentions in undertaking this preliminary survey, followed by a detailed account of the methodological approach taken in designing the survey and concluding with a consideration of the ethical challenges inherent in requesting information from public authorities.

## 4.1 Aims

A key limitation of previous work in exploring the role of the social worker in mental health services was the contextual homogeneity of the participants (Tucker and Webber, 2021; Abendstern et al, 2021; Woodbridge-Dodd, 2017; Norman and Peck, 1999). All studies were relatively small in scale, taking place within single or limited practice contexts. While participants themselves were not necessarily homogeneous within each study, diversity within the sample is not equivalent to representativeness (O'Connell Davidson and Layder, 1994) and without an alternative context for comparison, led to the potential for unseen homogeneity to influence the results in unmeasurable ways.

Understanding the wider context is not without difficulty, however. Cataloguing mental health social work in its range of integrated and non-integrated contexts is challenging. The localised nature of service provision and recordkeeping precludes gathering an overall picture of the workforce, making it challenging to explore the extent to which the context of practice influences understandings around roles (Chalk, 1999). Although informed by policy on a national level (Gibb et al, 2002), with mental health services planned and delivered on an organisational and geographical basis, there remains no clear oversight of or format to

this structure, with services build around fully integrated, partially integrated and unintegrated models (NHS Benchmarking, 2018) and service design and delivery decided on a local basis, generally informed by practitioner availability or historical precedence (Evans et al, 2012; Beinecke and Huxley, 2009; Duggan et al, 2002). Even the exact number of mental health social workers is unclear; although Approved Mental Health Professional (AMHP) provision is well documented (Skills for Care, 2021a), records of social worker provision tend to be delineated by adults and children's workforces and between NHS and local authority provision (Skills for Care, 2020b; Local Government Data Unit Wales, 2020). No central record exists for the overall mental health social work workforce, with informal estimates for England from the Department of Health and Social Care ranging between 4,300 and 8,000 within local authorities, and between 900 and 3,000 within the NHS (Trewin, 2019) and no information available for the Welsh context.

This first phase of the study was intended to develop a robust sampling framework detailing the position of social work within the mental health service structure nationally. Understanding this context is independently useful in terms of understanding the workforce and the current use of resources in order to inform workforce planning (Evans et al, 2012). It was also critical for later phases of the research exploring the role of social work within the context of mental health services to ensure that the significance of the environment of practice can be explored in depth.

This phase therefore intended to meet the following aims:

- To establish a more robust estimate of the number of mental health social workers currently employed in England and Wales
- To establish where this social work provision is positioned within NHS and local authority settings.

## 4.2 Methods

Critical to this element of the study was gaining a comprehensive understanding of the overall structure of mental social work in order to provide a framework from which to

sample for later stages. Kemper et al (2003) highlight six key elements to an effective sample:

1. Samples should be derived from the conceptual framework and research question underpinning the study
2. Sampling should generate a thorough database of the phenomenon under study
3. Sampling should enable credible inferences to be drawn from the data
4. Sampling should be feasible and ethical
5. Sampling should enable generalisability or transferability to a wider population
6. Sampling should be efficient

In order to achieve a sample that met these objectives, an overall understanding of the population under study was essential. Building a complete sampling frame is acknowledged to be challenging (O'Connell Davidson and Layder, 1994); however, incomplete or presumed frameworks lead to a risk of subsequent systemic error which risks excluding non-standard or hidden groups (O'Connell Davidson and Layder, 1994) and necessitates the gathering of comprehensive background information as far as is possible.

Use of surveys to provide a brief, exploratory preparation for further investigation is a longstanding methodological approach in social research (Bryman, 1988). In line with the stated objective to obtain a comprehensive picture of the mental health social work workforce a cross-sectional survey was issued to 173 Local Authorities responsible for delivering social work services and to 54 Mental Health Trusts and 7 Local Health Boards responsible for delivering mental health services in England and Wales. Collection of data was restricted to these two regions of the UK due to the substantially different legislative frameworks in both Northern Ireland and Scotland, which rendered the basis for comparison invalid (Mackay, 2012; Wilson and Daly, 2007). Data was collected via a brief questionnaire due to the low demand this placed on service providers and the numerical nature of the required data (Liu, 2008). This questionnaire was reviewed both within and external to the research team to ensure congruence between communicated meaning and intended meaning (Hakim, 2000).

Composition of the survey was different for local authorities and NHS providers to acknowledge their varying priorities and responsibilities in the provision of mental health care. In both cases, surveys were restricted to four questions to minimise the burden of providing the information and to maximise responses (Robson, 2011). Surveys were drafted and then reviewed separately by two academics familiar with the research questions and the format was revised based on the feedback received. Questions covered the following key areas:

1. Number of social workers working primarily with mental health needs directly employed by the organisation
2. Proportion of these social workers operating as part of the AMHP workforce
3. Positioning of these social workers within services
4. Details of any social work services commissioned from external providers.

Local authorities were also asked to give details of any agreements regarding the provision of mental health services with their respective Mental Health Trusts in order to develop a nuanced understanding of the level of service integration operating on a regional basis.

The standardised format of the questions was intended to maximise reliability and validity (Sapsford, 1999) and to ensure transparency and facilitate replication (Hakim, 2000), with questions formulated to minimise double counting, given the potential for local authority social workers to be working directly within NHS settings. Inclusive definitions of 'mental health service' and 'mental health social worker' were also used. While acknowledging that such standardised definitions can limit understanding, the targeted broad scope aimed to minimise the influence of interpretive bias, acknowledging both the socially constructed nature of survey responses (Williams and May, 1996; O'Connell Davidson and Layder, 1994) and the relationship between meaning and social conventions (Marsh, 1982).

## 4.3 Ethics

Ethical approval for the study was obtained from the University of York. It was confirmed with the Health Research Authority (HRA) both through use of their online assessment tool

and via a further clarifying email that further approval was not needed as the proposed nature of the data collection did not meet their criteria for research (Health Research Authority, 2019).

Research does not occur in isolation, but rather within a legal and ethical framework which influences data collection (Tarling, 2006). As the intention was to comprehensively map social work provision nationally, the target response rate was 100% to minimise misrepresentation (O'Connell Davidson and Layder, 1994). However, response rates for surveys generally fall significantly short of this (de Vaus, 2014). To counteract this, the initial research design used the Freedom of Information Act 2000 (FOI), which creates a general right of access to information held by public authorities and, by extension, places a legal duty upon such authorities to provide this information on request. The FOI covers all public authorities in England and Wales, including local authorities and NHS trusts, which positioned it as a useful resource for a comprehensive, exploratory enquiry of this nature (Bows, 2017). However, while academic use has increased in recent years (Atkinson et al, 2019) research access to the legislation has remained consistently under-used (Atkinson et al, 2019; Gillin and Smith, 2019; Meichner and Worthy, 2018; Bows, 2017; Shepherd et al, 2009; Lee, 2005).

Although some have lauded FOI approaches as a valuable new methodological tool within the social sciences (Atkinson et al, 2019; Lee, 2005), FOI requests have been a source of significant debate within academic and practice communities. Proponents of the process have suggested that it can demonstrate positive co-production potential with Freedom of Information officers, who appreciate the value of contributing to knowledge-building activities whilst also providing invaluable access to critical data (Bourke et al, 2012); especially the grey literature which helps to inform an understanding of how public authorities act where there is no formal policy in place (Hammond et al, 2017) and that it focuses access to large scale data held by public authorities which can be critical in developing an understanding of the need for further research (Savage and Hyde, 2014).

These specific arguments highlighted the relevance of FOI to this particular study, which aimed to build a comprehensive understanding of an area of service delivery not previously

defined. Compounding this was the noted impact of FOI on response rates; while requests can be made informally, the impact of a legislative framework and specific requirement for public authorities to respond has been identified as having a positive and marked influence on response rates by comparison to an informal enquiry (Worthy et al, 2017; Fowler et al, 2013), although this is not a universally observed effect (Worthy et al, 2017).

Critics, on the other hand, have raised concerns around the extent of the request burden placed upon public authorities, both in terms of time and financial costs (Independent Commission on Freedom of Information, 2016; Breathnach et al, 2011) and in terms of the exponential increase in cost when requests are made to multiple authorities, a factor which was integral to the current research design (Fowler et al, 2013). It has been repeatedly noted that local authorities bear the majority of the burden of FOI requests, accounting for between 60% and 80% of enquiries (Meijer et al, 2018; Worthy et al, 2017; Worthy, 2013), with the result that general trawls, which this study could be seen as, are viewed unfavourably (Lee, 2005).

The importance of maintaining good relationships between social researchers and their collaborating organisations underpin a key concern in the use of FOI for research purposes. The coercive nature of FOI requests, which exist in opposition to general ethical research guidelines are also frequently cited (Hammond et al, 2017; Breathnach et al, 2011). It should be noted, however. that such requests are aimed not at volunteer research participants, but made through a legally defined process which places an obligation upon an organisation (Singleton, 2011) and supports the transparency and accountability of public authorities (Dunion, 2011), rendering this comparison less than equitable. Nonetheless, it has been extensively argued that the effectiveness of FOI is reliant on the goodwill and engagement of organisational gatekeepers (Bows, 2017; Lee, 2005) in an environment where FOI has been presented as politically unpalatable, excessively burdensome and as a tool with which to attack co-operating organisations (Jamieson et al, 2019; Hazell and Worthy, 2010)

The ongoing debate has not yet led to an agreed academic approach to FOI (Bows, 2017). The public benefit of access to largescale data which would be otherwise inaccessible

(Fowler et al, 2013) is argued to justify use of the provisions in an academic setting, caveated by the necessity for their skilled and considered use rather than potentially inappropriate, blanket application (Hammond et al, 2017). It is perhaps telling that the Burns Commission (Independent Commission on the Freedom of Information, 2016), when presented with an overwhelming body of evidence relating to the burden versus the benefit of Freedom of Information requests felt that precedence should be granted to the "general public interest in accountability and transparency of public bodies" (Independent Commission on Freedom of Information, 2016, p.48).

In the context of the above debate and in the absence of formal guidance, requests for information were sent informally and without recourse to the legislative framework. Instead a cost-benefit approach was adopted; in addition to the survey being designed to be as non-intrusive as possible, public bodies were offered access to the findings of the survey (Dillman et al, 2014) and the research purposes explained to ensure an understanding of relevance (Savage and Hyde, 2014). However, FOI does not require the requester to specify that their request is made under the provisions of the Act (Freedom of Information Act, 2000). Instead, responsibility to decide applicability rests with the public authority (Bows, 2017; Fowler et al, 2013). Despite the researcher's intentions, requests were without exception treated as being made under the legislative provisions. Due to the potential to sour research relationships for both this and future studies (Hughes et al, 2000), although two follow up requests were sent, no formal process was undertaken to pursue non-responders (Hammond et al, 2017).

## 4.4 Data Analysis

Descriptive statistical analysis was undertaken using SPSS (version 25) to explore the characteristics of the dataset and to develop a framework which could adequately demonstrate the structure of provision and be used to develop the sampling framework for subsequent phases of the research. To enable understanding, additional data fields which were not direct questions on the survey were added to ensure clarity and reflect the complexity of the survey responses. These included:

- *External AMHP workforce:* This identified where the reported AMHP figures included workers based outside of mental health services. These most frequently related to AMHPs employed to work exclusively within generic Emergency Duty Teams
- *Hybrid working arrangements*: This identified local authorities who reported a range of working arrangements for social work staff (namely a mixture of staff based within both local authority and NHS teams).

Further statistical exploration investigated any links between organisational characteristics and the structure of their mental health social work provision. The near census level nature of the data precluded the use of statistical tests of association (Knapp, 2017) and data was therefore analysed through inspection of the actual differences around the theoretically informed variables which derived from the research question. Analysis of these differences was framed around a model of practical significance, considering whether any observed differences were meaningful in the context of either the extent to which they occurred or the implications for service provision they carried.

# Chapter 5 - Results: Establishing a preliminary understanding of the structure of mental health social work provision.

Context is critical in understanding the significance of research findings in the social sciences (Bryman, 1988). With understanding of the specific structure of mental health services in England and Wales shrouded by a lack of clarity, the analysis of the initial responses to the service provider survey aimed to illuminate this by addressing the preliminary aims of the study in establishing estimates of the size of the mental health social work workforce and an overview of how this workforce was distributed across the different practice contexts within both nations. This led to a primarily descriptive exploration of the data, aimed at presenting a picture of mental health services which was rich in the detail of the form and function of mental health social work. To this end, this chapter initially outlines the organisational structures underpinning mental health social work, before addressing staffing distribution across organisations, team types and geographic locations. While the nature of the data did not lend itself to a causal analysis (O'Connell Davidson and Layder, 1994), the chapter concludes with an exploration of the statistical associations between organisation characteristics and the social work workforce to help identify any underlying understanding which inform how these services are structured and delivered.

## 5.1 Response rates

Surveys were issued between February and May 2019, and responses returned between March and September 2019. Requests were sent to a total of 237 public authorities, including 173 local authorities, 57 NHS trusts and 7 Local Health Boards. Response rates were very high, overall 96.6%. Responses were not received from six local authorities and from two NHS trusts (table 5.1).

| Organisation type | Total number of requests (%) | Total number of responses (%) | % responses within type |
|---|---|---|---|
| NHS Trust | 57 (24%) | 55 (23.2%) | 96.4% |
| Local Health Board | 7 (3%) | 7 (3%) | 100% |

| | | | |
|---|---|---|---|
| Local Authority | 173 (73%) | 167 (70.5%) | 96.5% |
| Missing | | 8 (3.3%) | |
| **Total** | **237 (100%)** | **237 (100%)** | **96.6%** |

Table 5.1: Response rates by organisation types

Local authority structure across England and Wales is non-uniform and local authority responses were classified by their authority sub-type in addition to being recorded as local authorities. 100% response rates were achieved from County Councils and Metropolitan Borough Councils. Unitary Councils had a response rate of 96.4%, London Borough Councils had a response rate of 93.9% and Welsh Councils had a response rate of 90.5% (table 5.2).

| Local Authority Sub-type | Total number of requests (%) | Total number of responses (%) | % responses within type |
|---|---|---|---|
| Unitary | 56 (32.4%) | 54 (31.2%) | 96.4% |
| Metropolitan Borough | 36 (20.8%) | 36 (20.8%) | 100% |
| County | 27 (15.6%) | 27 (15.6%) | 100% |
| London | 33 (19.1%) | 31 (17.9%) | 93.9% |
| Welsh | 21 (12.1%) | 19 (11%) | 90.5% |
| **Total** | **173 (100%)** | **167 (96.5%)** | |

Table 5.2: Local authority response rates by sub-types

## 5.2 The Mental Health Social Work Workforce

The total number of social workers working directly in mental health provision was 6,584.82, across 228 organisations. Of this total, 1,536.77 (23.3%) were identified as specifically working with adults and 435.90 (6.6%) as specifically working with children. For the remaining 4,612.15 (70.1%), the client group was not identified (table 5.3). While a direct comparison is challenging due to the organisation of workforce counts, this suggests that mental health social workers may comprise around a quarter of adult social care workforce in England, and a fifth of the workforce in Wales, with a much smaller proportion

of mental health social workers in children's services (Skills for Care; 2020b; Local Government Data Unit Wales, 2020).

| Organisation type | Total number of mental health social workers (MHSWs) | Number of adult MHSWs | Number of children's MHSWs | Number of AMHPs |
|---|---|---|---|---|
| NHS Trust | 2,144.10 | 1,211.77 | 393.90 | 236 |
| Local Health Board | 53.50 | 19 | 32.50 | 7 |
| Local Authority | 4,387.22 | 306 | 9.50 | 2,972.60 |
| **Total** | 6,584.82 | 1,536.77 | 435.90 | 3,215.60 |

Table 5.3: Mental health social work numbers (FTE) by organisation type

The minimum number of social workers employed within a single organisation was 0 (n=30) and the maximum number was 147 (n=1). Distribution of social work employment was positively skewed. 66.6% (n=4,387.22) of social workers were employed by local authorities, 32.5% (n=2,144.10) by NHS trusts, and 0.8% (n=53.50) by Local Health Boards.

The total reported number of AMHPs was 3,215.60. This number included AMHPs who were employed outside of direct mental health provision (most commonly with generic Emergency Duty Teams), with 34.5% (n=79) of organisations giving AMHP figures including those based outside mental health provision. The vast majority of these cases were local authorities, including only one NHS trust. 92.4% of AMHPs were employed by local authorities, 7.35% by NHS trusts, and 0.25% by Local Health Boards.

## 5.3 Mental Health Social Work Providers

### 5.3.1 Local Authorities

Social workers were employed to work directly in mental health settings by 86.8% (n=145) of local authorities. For the remaining local authorities, provision in mental health settings was outsourced to an outside organisation (n=1), to the NHS (n=15) or service provision within the authority included no mental health specialism (n=6).

Over half of local authorities reported having social workers in-house (58.1%, n=97) and approximately two thirds reported employing social workers based in NHS teams either with local authority oversight (36.5%, n=61) or without local authority oversight (31.1%, n=52). 30.5% (n=51) of local authorities employed social workers in a mix of different settings within both the NHS and the local authority. This division generally related to different arrangements for the AMHP workforce as opposed to their general mental health workforce.

Local authorities had varied working relationships with NHS partners. The most common arrangement was a formal working agreement (55.1%, n=92), of which 35.3% (n=59) were specifically identified as 'Section 75' arrangements (Health Act 2006). 28.1% (n=37) of local authorities reported an informal working arrangement, most often based on working practices or co-location of non-integrated staff. 3% (n=5) of local authorities reported a hybrid arrangement, with different agreements across different service areas and 13.8% (n=23) reported no working agreements in place.

### 5.3.2 NHS and Local Health Boards

Social workers were employed directly in mental health settings in 89.1% (n=49) of NHS trusts and in 71.4% (n=5) of Local Health Boards.

NHS trusts and Local Health Boards employed social workers across the full range of service provision. Organisations were most likely to employ social workers in crisis services, with 59.7% (n=47) employing in this capacity. However, the largest number of social workers were employed in working age adult services (n=536). Inpatient services were both the least common base for social workers, with only 41.9% (n=26) of NHS trusts and no Local Health Boards employing staff in this area, and the area with the fewest number of social

workers employed (n=46). Social workers employed in other areas included management and commissioning roles, specialist services (such as substance misuse), Assertive Outreach, Liaison services, Perinatal services, and social care specific roles (table 5.4).

| Service Type | Number of employing NHS trusts | Number of employing LHBs | Total number of MHSWs |
|---|---|---|---|
| Child and Adolescent Mental Health Services | 33 | 2 | 427 |
| Early Intervention in Psychosis | 29 | 1 | 96 |
| Working Age Adults | 35 | 1 | 536 |
| Older Adults | 29 | 1 | 74 |
| Forensics | 31 | 1 | 129 |
| Inpatients | 26 | 0 | 46 |
| Crisis | 33 | 4 | 118 |
| Other | 31 | 3 | 495 |

Table 5.4: NHS MHSWs by employment type

With the exception of three local authorities who outsourced their social work provision entirely to community interest companies, neither NHS trusts nor local authorities externally commissioned mental health social work services.

## 5.4 Mental Health Social Work by Location

Geographic location was considered by regions, as the highest level of bureaucratic structuring within the country. Local authorities were congruent with these regional boundaries. Where this was not the case for NHS organisations, each was assigned to an area based on where it operated most prominently. Where this was unclear, organisations were allocated based on the location of their head offices.

Social workers were employed in all areas of England and Wales, with the highest number of employing agencies in London (n=40) and the lowest in the East Midlands (n=13) (table 5.5).

| Area | Number of employing NHS trusts | Number of employing LAs | Total number of employing agencies |
|---|---|---|---|
| East | 4 | 11 | 15 |
| East Midlands | 4 | 9 | 13 |
| London | 9 | 31 | 40 |
| North East | 2 | 12 | 14 |
| North West | 7 | 23 | 30 |
| South East | 8 | 19 | 27 |
| South West | 7 | 14 | 21 |
| Wales | 7 | 19 | 26 |
| Yorkshire and the Humber | 7 | 15 | 22 |

Table 5.5: MHSW employers by geographic area

The area employing the highest number of social workers was London (n=1099.13) and the lowest was Wales (n=335.7). Broadly, social worker numbers correlated to population figures for the local areas, with the exception of Yorkshire and the Humber (ranked 4 for social workers and 7 for population) and East (ranked 7 for social workers and 4 for population) regions (table 5.6).

| Area | Total number of MHSWs | Mean (compared to national average of 28.8) | Rank by total number employed | Population (rank)* | Amount of population covered per MHSW |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| East | 526.42 | 39.05 (+10.25) | 7 | 6,130,542 (4) | 11,646 |
| East Midlands | 400.4 | 30.80 (+2) | 8 | 4,724,437 (8) | 11,799 |
| London | 1099.13 | 28.18 (-0.62) | 1 | 8,787,892 (2) | 7,995 |
| North East | 384 | 27.43 (-1.37) | 9 | 2,636,848 (10) | 6,867 |
| North West | 962.5 | 32.08 (+3.28) | 3 | 7,219,623 (3) | 7,501 |
| South East | 975 | 36.11 (+7.31) | 2 | 9,026,297 (1) | 9,258 |
| South West | 606.5 | 28.88 (+0.08) | 5 | 5,515,953 (6) | 9,095 |
| Wales | 335.7 | 12.91 (-15.89) | 10 | 3,113,150 (9) | 9,274 |
| West Midlands | 600.17 | 28.58 (-0.22) | 6 | 5,800,734 (5) | 9,665 |
| Yorkshire and the Humber | 695 | 31.59 (+2.79) | 4 | 5,425,741 (7) | 7,807 |

Table 5.6: Number of MHSWs (FTE) in comparison to general population by geographic region

* (Office for National Statistics, 2017)

## 5.5 Mental Health Social Work Provision

Exploring the significance of context to understanding mental health social work as a professional role requires an understanding of how the different aspects of the practice setting interrelate. While correlations are not causal and linking these definitively to subsequent explanations of mental health professional role in context would be inadvisable (Field, 2013), understanding potential relationships built into the structures of service provision were deemed to be potentially useful in interpreting the subsequent qualitative experiences reported in later phases of the study. With this in mind, the relationship between organisational types, organisational locations, numbers of social workers and organisational relationships was explored to identify prospective links. Analysis was limited

to those elements which were viewed as likely to have a direct effect on the experience of the practice context, namely integration, location, workforce and organisation.

### 5.5.1 Organisation type and numbers of social workers

There was no observable pattern between the number of social work staff employed by a local authority and the number employed by an NHS trust (for the purpose of analysis, Local Health Boards were incorporated into NHS figures due to the low numbers involved). Local authorities accounted for 73% of the organisations with staffing responsibilities in this area and employed 67% of the social work staff. Given that social work provision in mental health is a local authority responsibility, it might be expected that local authorities should provide a higher proportion of the provision. This in turn might give weight to the suggestion that NHS providers have needed to address a shortfall in social work provision linked to a withdrawal of social worker provision from integrated services to address core local authority responsibilities (Lilo, 2016).

A fuller review of the data, however, suggests this interpretation would be over-simplistic, and two key factors also need consideration. Firstly, NHS social work provision in part was explained by the 8.6% (n=15) of local authorities who outsourced their mental health social work provision directly to the NHS. Although funded by local authorities, these staffing figures were reported within the survey as NHS provided, thereby inflating the level of NHS provision in those areas of practice local authorities hold responsibility for. Secondly, slightly less than one in five (19.4%) of NHS-employed social workers were situated within child and adolescent mental health services, an area of mental health social work provision not expected by local authorities. The breakdown of employment areas within the NHS highlights this trend, with social work provision distributed across a range of areas outside of the local authority responsibility.

### 5.5.2 Organisation location and numbers of social workers

As previously discussed, the distribution of social work provision mapped broadly to the population figures for each region of England and for Wales (Office for National Statistics,

2017), with the exception of the East of England, which was under-represented in social work provision based on the population and Yorkshire and the Humber, which was over-represented correspondingly (Table 5.6). This discrepancy can perhaps be explained by the high number of populous urban areas within Yorkshire and the Humber, which account for some of the most densely populated areas within the UK (Office for National Statistics, 2021c). This could in turn contribute to a concentration of mental health social work provision within these areas. By contrast, despite having a markedly high population in the national context, the East region lacks similar pockets of population density that may trigger such provision.

### 5.5.3 Local authority sub-type and numbers of social workers

While London-based organisations overall employed the most mental social workers on a geographic basis, this trend did not hold true when compared across local authority subtypes.

| | Total number of MHSW employed (% of overall LA total) | Minimum employed | Maximum employed | Mean number of MHSWs employed |
|---|---|---|---|---|
| County | 1227.6 (28.0) | 0 | 143 | 45.5 |
| Metropolitan | 1055.5 (24.1) | 0 | 97 | 29.3 |
| London | 753.7 (17.2) | 0 | 51 | 25.1 |
| Unitary | 1068.2 (24.3) | 0 | 111 | 19.8 |
| Welsh | 282.2 (6.4) | 4 | 34 | 14.9 |

Table 5.7: Mental health social worker provision by local authority subtype.

London and Welsh local authorities employed the overall lowest proportion of mental health social workers even when combined, although, in line with previous observations relating to population size, provision in these two areas scaled against one another in line with population levels. Furthermore, the smaller number of London local authorities as compared to unitary authorities meant that on average, the number of mental health social

workers per organisation in London was higher, perhaps reflecting the corresponding population density.

The remaining workforce was split broadly evenly across the three different subtypes of local authority, although the numbers per organisation were spread widely both in terms of actual count and by measurement of the mean numbers employed per organisation. The relatively small number of county councils meant that, on average, these authorities employed more than twice the number of mental health social workers that unitary authorities did, with metropolitan councils falling between the two (table 5.7).

While a clear explanation for this variation is difficult to establish from the available data, the tendency for county councils to be geographically larger (Ministry of Housing, Communities and Local Government, 2019) may offer a practical explanation. The local authority contribution to mental health care is predominantly community based and both health and social care provision within community settings is geographically organised, with general mental health and social care teams working with a geographic subset of the population. The expectation that county councils might require a higher number of such teams to cover a broader geographic area may explain, although a more detailed inspection of the structure of provision within organisations would be required to explore this more fully.

### 5.5.4 Local authority sub-type and relationship with NHS

Formal relationships were the dominant relationship type for all sub-types of local authority in England, whereas for the Welsh Local Authorities, informal relationships were predominant, which may be reflective of the devolved nature of health and social care provision within Wales and the differing priorities of the Welsh Government in delivering these (table 5.8).

| | Number with formal relationships (%) | Number with informal or hybrid relationships (%) | Number with no relationship (%) |
|---|---|---|---|
| County | 18 (66.7) | 8 (29.6) | 1 (3.7) |
| Metropolitan | 17 (47.2) | 12 (33.3) | 7 (19.4) |
| London | 23 (74.2) | 2 (6.5) | 6 (19.4) |
| Unitary | 30 (55.6) | 16 (29.6) | 8 (14.8) |
| Welsh | 4 (21.1) | 14 (73.7) | 1 (5.3) |

Table 5.8: Nature of the organisational relationships with the NHS based on local authority sub-types

Overall, 55.1% of local authorities reported formal working relationships, however, split across different local authority types, this ranged between half and three quarters of local authorities within the different local authority subtypes in England, and dropped to one fifth of local authorities in Wales. Among the English subtypes of local authority, London-based local authorities were most likely to have a formal working relationship with the NHS in place, while metropolitan councils were the least likely. However, all varieties of relationship were reported across all local authority subtypes.

Deriving meaning from this variation is challenging, due to the organisational diversity within the different subtypes of local authorities and the variation within the structure of health and social care provision across the country. County councils are more likely to serve rural areas than metropolitan councils (Ministry of Housing, Communities and Local Government, 2019), while metropolitan and London councils see higher levels of deprivation (Atkins and Hoddinott, 2022). Such trends are not definitive, however, and variation within the population is reflected in the areas these authorities serve. While analysis of the characteristics of each local authority area is beyond the scope of this thesis to explore, a localised focus in service provision which reflects the diversity in the social composition of the UK on a population wide scale, may offer an explanation for this variation.

### 5.5.5 Number of social workers and relationship with NHS

The majority of local authority mental health social workers (56.3%, n=2471.1) worked within organisational settings built around formal relationships with the NHS. This mirrored the domination of this organisational arrangement across the local authorities within the survey.

| | Total number of MHSW employed (% of overall LA total) | Minimum employed | Maximum employed | Total number of LAs by relationship type (%) |
|---|---|---|---|---|
| Formal relationship | 2471.1 (56.3) | 0 | 143 | 92 (55.1) |
| Informal or hybrid relationship | 1300.0 (29.6) | 0 | 97 | 37 (31.1) |
| No relationship | 516.1 (11.8) | 0 | 52 | 23 (13.8) |

Table 5.9: Local authority mental health social worker provision based on structure of the health and social care working relationship.

Distribution of the workforce across the different working relationship structures broadly matched with distribution of those structures (table 5.9). Drawing meaning from this correlation with any level of confidence is again challenging, given the heterogeneity of organisational provision, and the lack of consistency in relation to local authority and NHS trust boundaries and provision. Nonetheless, the lack of a clear overall pattern of provision does contribute to the interpretation of mental health social work provision as locally driven and locally defined.

### 5.5.6 Conclusion

Previous estimates of the mental health social work workforce have been wide and broad ranging, rooted in local and partial approximations (Trewin, 2019) or lacking entirely. In the

context of an exceptionally high response rate, this analysis provides a more comprehensive overview of how and where this workforce is positioned within the wider mental health service structures, contributing to a more detailed understanding and fuller discussion of how social work is deployed and positioned within mental health.

A fuller discussion of the implications of these findings will follow later in this thesis; however, as reported here, they provide a robust and contemporaneous map of the national mental health social work provision across England and Wales. This enables the further exploration of professional role and contextual influences intended in the following two phases of this study to be positioned and explored.

# Chapter 6 - Methodology: Exploring mental health social worker perspectives on role in context.

Establishing the structure of mental health social work across England and Wales permits a more concrete and comprehensive understanding of where and how mental health social work is provided than had previously been available (Trewin, 2019). However, this understanding on its own is superficial. Awareness of how mental health social work is structured provides a framework for positioning what mental health social work is, but not the insight to understand the professional role or how it is affected by its environment. The next two stages of the research combined a national survey of mental health social workers with subsequent in-depth interviews with a sub-sample of the survey participants to address these primary research questions of how mental social workers understand their role and how this is influenced by their practice environment from a multi-faceted perspective that aimed to provide both breadth and depth of perspective through both qualitative and quantitative approaches (Cresswell and Piano Clark, 2007). This combination of data and methodological pluralism aimed to increase the robustness of the findings and to mitigate against any potential bias arising from the solo researcher (Olsen, 2004).

This chapter explores the methodological underpinnings of this approach, beginning with the aims of the research and the use of the preliminary findings in supporting prospective participant sampling. Approaches to data collection for both the survey and the interviews are then considered, followed by the respective approaches to analysis of the data, before concluding with a consideration of the ethical implications inherent in the research, including the significance of undertaking such research in the context of a global pandemic.

## 6.1 Aim of the research

Exploration of mental health social work has historically focused on qualitative approaches undertaken in the small scale whilst also frequently identifying context as critical in understanding the role (Abendstern et al, 2021; Tucker and Webber, 2021; Bailey and Liyanage, 2012; Peck and Norman, 1999). An over-reliance on small-scale studies, however, can mistakenly lead to the belief that a baseline understanding has been established which

is not actually in place (Kelly et al, 1992). To develop an understanding of the significance of context, a broader understanding of the mental health social work role was necessary, positioning the contextual detail alongside a widespread overview (Silverman, 1998). In order to highlight those aspects of the role which appear universally, regardless of context, while also identifying those areas in which context influences variation, an approach to data collection which transcended organisational and geographic boundaries was necessary.

This second stage of the study therefore adopted a multi-site comparative mixed methods approach, with data was gathered initially through a widescale survey, followed up by interviews with a purposively selected sub-sample of participants. By adopting this triangulated approach to data collection, the study differentiated between method as a technical tool and methodology as an underpinning approach which determines the validity of knowledge around social realities (Ramazanoglu and Holland, 2002; Williams, 2002). To this end, it used a range of tools aimed to gather differing perspectives on mental health social work which both contextualised the detail, but also detailed the context (Williams, 2002; Bryman, 1998).

## 6.2 Preparation, Access and Sampling

Due to the desire of this study to represent a range of practice contexts as an integral aspect of addressing the research question, fully random sampling of participants was deemed inappropriate due to the potential for elements of the target population to be under-represented (Laws et al, 2003; O'Connell-Davidson and Layder, 1994). Instead, multi-stage stratified sampling was intended to include both a purposive and a randomised element, with the sampling framework derived from the initial stage of the study looking at mental health social work provision used to pre-select a representative sample of NHS trusts, Local Health Boards and local authorities which ensured all permutations of mental health social work were represented. While this purposive approach would reduce generalisability in favour of ensuring relevance (Shipman, 1997), the focus of the purposive sample in ensuring the range of experiences within practice were included was intended to mitigate for this by reducing homogeneity in the participant characteristics (Flick, 2009). Acknowledging that social work investment in research about itself inherently raises risks of bias, due to the

investment in the processes of practice (Smith, 2009), random sampling of prospective participants in each location was intended to minimise the risk of vested interest bias (Arksey and Knight, 1999). However, this approach proved impractical in reality for two key reasons: the nature of mental health social work provision on the national scale, and the impact of the coronavirus pandemic.

The preparatory data demonstrating the structure and provision of mental health social work detailed in the preceding chapters highlighted a complex tapestry of service provision, reflecting and confirming previous research indicating the lack of an overarching structure (Wilberforce et al, 2015; Burn and Lloyd,2004). Social workers were widely employed within both local authority and NHS settings, with no clear preferred model of practice emerging, reinforcing assertions that provision is ad hoc, driven by local priorities, relationships, and conventions rather than by a more comprehensive plan (Evans et al, 2012) and reinforcing perceptions that workforce planning is health focused to the exclusion of social work (Anderson et al, 2021). This diversity presented significant challenges in stratifying organisations in order to build a representative sample of contexts. While it was possible to broadly divide provision types into lists built around mental health social work provision in separate, co-located or integrated contexts, this division represented a high level of heterogeneity within each category, meaning that any sample selected within them risked excluding any given approach to service provision from the final sample.

This issue in turn was compounded by the impact of the coronavirus pandemic. Local authority and NHS organisations experienced significant pressure arising from the wider social and health related effects of the pandemic, which impacted negatively both in terms of financial and staffing resources (Warner and Zaranko, 2021; House of Commons Health and Social Care Committee, 2021; 2020). The original research design necessitated a higher level of engagement and burden upon the selected sample sites than was ideal in the context of this increased level of demand and conflicted with the HRA's research priorities at the time, which were focused on research related to the coronavirus pandemic (Health Research Authority, 2020).

The study therefore adopted a combination volunteer and snowballing approach to sampling (O'Connell Davidson and Layder, 1994). Adopting an approach based on least impact, local authorities and NHS trusts were asked to share details of the study within the practice contexts where mental health social workers operated through whichever means was most convenient for them. Recommended approaches were through email mailshots or staff newsletters. However, to complement this, information about the survey was also distributed through social media networks, acknowledging the position of social media as an academic and practice space (Greeson et al, 2018; Hitchcock and Battista, 2013) and through social work contacts of the principal researcher, aimed at accessing social work networks beyond the academic context.

The sample recruited was therefore one of convenience rather than design. This is not ideal due to the potential for bias and misrepresentation (Robson, 2011) and the risk that it specifically recruits those with a vested interest in the research question, thereby excluding the views of those who hold more ambivalent views. However, this revised approach did allow for some benefit. Removal and minimisation of the gatekeeper element of participant selection reduced the potential for gatekeeper selection bias (Noaks and Wincup, 2004); the study became less reliant on negotiated access to the participant group. In addition the overview of practice structures as afforded by the initial survey of organisations allowed for the researcher to assess how broad the scope of recruitment had been. While not ideal, this approach highlighted the inherent conflict between the ideals of research design and the limitations of research realities (Bechhofer and Paterson, 2000), while also reflecting the necessity for social work research to be fluid and flexible rather than intransient and fixed (Broad, 1999).

## 6.3 Methods: the social survey

Self-administered anonymous survey responses were collected from 248 participants through Qualtrics between April and October 2020, with initial launch of the survey delayed due to the impact of the coronavirus pandemic. The criteria for participation were inclusively broad (Peters, 2010). Participants were invited to participate if provided they met two criteria; they were practicing as qualified social workers, registered with Social

Work England or Social Care Wales, and their primary field of practice was in mental health. Participation was limited to these two regions of the UK to reflect their shared mental health legislative framework; social workers within Northern Ireland and Scotland were excluded as the broadly different legislative context for practice would render comparison challenging (Mackay, 2012; Wilson and Daly, 2007). Practice in mental health was deliberately broadly framed and left open to participant self-definition. This reflected the broad diversity of practice contexts identified in the initial phase of the study and ensured that participants were not unduly excluded due to externally imposed criteria.

Survey responses were collected anonymously, with no option for the researcher to identify participants from their survey responses. The only exception was for participants who wished to be considered for inclusion in the follow up interviews. In this instance, participant email addresses were linked to a partial subset of their data in order to allow for purposive sampling, and this was clearly communicated to participants in the pre-participation information (de Vaus, 2014). This combination of anonymity and an openly accessed internet survey does raise potential concern regarding the appropriateness of access, as participants were required to self-screen for eligibility (de Vaus, 2014). To counter unintentional inappropriate access, detail relating to the eligibility criteria was included both in the participant consent, which required active acknowledgement, and in the initial background and demographic questions. The risk of deliberate inappropriate access was assessed as minimal due to both the nature of the research topic and the length of the survey to complete. By contrast, the benefits of anonymity arguably outweighed this risk, as combined with the single contact cross-sectional nature of the survey (de Vaus, 2001) this gave scope for participants to present negative views of their employing organisations and working environments without fear of recrimination and therefore worked to encourage participation.

Recognising the limitations of a cross-sectional survey in establishing causal links (Bowling, 2009), this study aimed to identify correlations between perspectives on role and practice context. However, establishing an appropriate sample size was challenging. The exploratory nature of the study posed a barrier to meaningfully undertaking formal power calculations, and, indeed, it has been suggested that such calculations hold less relevance in

studies of this type (Jones et al, 2003). Critical to effectively addressing the research question was a thorough exploration of practice context and therefore a sampling strategy was adopted which drew on established approaches to rationalise target numbers but also prioritised reflecting diversity across the workforce.

To set sample size, the total population, including missing data, was estimated at 6,817 practitioners across approximately 200 organisations. Given the stated aim to recruit participants from across a range of practice contexts, an upper recruitment target of 350-400 was used, acknowledging de Vaus's (2014) suggestion that 400 should be the absolute survey sample size, with this higher target deemed appropriate due to the extensive number of practice settings. A minimum participant number was also set in recognition of the potential limiting impact of the coronavirus pandemic on recruitment. For this, Onwugegbuzie and Collins' (2007) position that correlational research requires a minimum sample size of 64 on a one-tailed hypothesis and 82 on a two-tailed hypothesis was adopted and the minimum target for recruitment was set at 82. However, working with this lower target was contingent on the spread of participants recruited reflecting the diversity of the workplace context and this was therefore deemed subject to change dependent on the actual recruitment demographics. To further ensure the exploration was indicative of the wider workforce as established in the preliminary exploration, this target was split, and aimed for 67% of participants being employed by local authorities and 33% being employed within the NHS.

Composition of the survey aimed to broadly address three key areas:

1. Background information: addressing general questions about the participant and their mental health social work experience in order to explore how representative the sample was of the wider mental health social work workforce
2. Social work and professional identity: exploring participants perspectives of what is significant in defining professional identity in relation to mental health social work
3. Social work and the practice environment: exploring participants experiences in the practice environment, looking at professional recognition and standing within their organisation, freedom to practice in line with professional standards, their ability to

influence service provision and the service user experience and attitudes toward social work within their work environment

Reflecting the complexity of questionnaire design and the difficulty in ensuring that questionnaires answer the questions they were intended to address, and that meaning was not inadvertently inferred through the means of communication (Hakim, 2000), priority was given to using previously validated instruments for data collection. This helped to ensure both the validity and robustness of the findings, as well as enabling comparison with other studies using the same approaches.

### 6.3.1 Survey composition: background questions

Background questions aimed to contextualise participants and to demonstrate the extent to which the sample recruited reflected the wider workforce. Furthermore, inclusion of participant characteristics beyond employment context enabled analysis of the data to explore for correlations in perspectives relating to these wider demographic characteristics. Questions in this section covered the following key areas:

1. Age
2. Ethnic background
3. Gender identity
4. Social work experience (time)
5. Mental health experience (time)
6. Employment context
7. Workplace context and previous experience

Due to the diverse nature of social work structures across England and Wales, location was excluded from the demographic information to ensure that any participants working in unique roles or contexts could not be identified by their answers. Data collection around identifying personal characteristics was undertaken in line with best practice guidelines relating to the phrasing of questions and response options (Office for National Statistics, 2021a, 2021b; Pasterny, 2016).

### 6.3.2 Survey composition: social work and professional identity

Measurement of professional identity was undertaken using a Single Item Social Identification measure (Postmes et al, 2013), in a three-part representation drawing on McCrae et al's (2004) typologies of social work in mental health ('mental health worker', 'mental health social worker' and 'social worker'). The key intention here was to explore the extent to which participants positively identified with these three aspects of identity, drawing on Tajfelian ideas of social identity as linked to a positive valuation attributed to membership of a particular social group (Tajfel, 1974). Single item identity measures have demonstrated high validity, reliability and utility particularly in relation to this aspect of self-identity (Postmes et al, 2013) and are deemed particularly suitable for use where surveys are overlong and in questions relating to work role centrality (Fisher et al, 2016).

To contextualise this understanding, exploration was also made of participants strength of sense of identity and an evaluation of a range of external factors which might impact on this. While no validated instrument existed to measure this, measure construction was informed with reference to an unvalidated instrument measuring similar concepts (Wiles, 2019) and through reference to the wider literature on factors influencing social work practice (Bradley McKibben, 2018). The initial measure was reviewed without prior discussion by the research supervisors, and correspondingly amended for clarity.

### 6.3.3 Survey composition: social work and the practice environment

Two validated measures were employed to measure the impact of the practice environment: the Practice Environment Scale of the Nursing Work Index (PES-NWI) (Lake, 2007) and the Culture of Care Barometer (Rafferty et al, 2015). The PES-NWI measures the nursing practice environment and its impact across five subscales:

- Participation in Organisational Affairs
- Staffing and Resource Adequacy
- Quality of Care

- Manager leadership, ability and staff support
- Relationship with health colleagues

While not specifically used for social workers historically, it has been used across a range of national settings (Nunez et al, 2021; Swiger et al, 2017; Warshawsky and Sullivan Havens, 2011), translated and validated in a number of languages (see, for example, Ogata et al, 2018; De Pedro-Gómez et al, 2011) and used with a subset of nursing related professions (Swiger et al, 2017) across cultural contexts (Nunez et al, 2021; Bryzski et al, 2016) with ongoing congruence and validity. In a UK context specifically, it was assessed as maintaining congruence, consistency and reliability when transferred from a general practice to a psychiatric specific context (Hanrahan, 2007), with the instrument generally functioning well with minor modifications across practice settings (Swiger et al, 2017).

The Culture of Care Barometer (Rafferty et al, 2015) by comparison was developed specifically for use within the NHS and measures the culture of a health working environment, in the context of staff commitment, engagement and productivity. Perspectives across the practice environment are measured across seven subscales:

- Engagement (communication and being informed)
- Empowerment (influence and being listened to)
- Leadership (management and role models)
- Values (recognition, respect and overall culture)
- Role (training and development)
- Resources (resources and time)
- Team (support from colleagues and manager)

Although demonstrating some crossover with the PES-NWI, the contextual relevance of this measure was deemed appropriate, to supplement the interpretation of the PES-NWI outside of its conceptual roots (Bryzski et al, 2016). The Barometer also focused on the interaction between the individual worker and their organisation, without being targeted at a specific professional group, but did demonstrate during development some sensitivity toward the interpretation variation across staff groups (Rafferty et al, 2015) in addition to

the interaction between staff and their organisation, granting it particular relevance in the context of this study.

## 6.4 Methods: the social interviews

Previous research has positioned mental health social work as both conceptual and reliant on tacit knowledge (Tucker and Webber, 2021). Social work operates within 'messy' contexts, across boundaries and amidst competing priorities (Dickens, 2011) and the survey approach, while offering a breadth currently absent from the literature, lacked the necessary depth to enable a comprehensive understanding of the mental health social worker role and contribution (Hakim, 2000). Individual perspectives are therefore critical in understanding the construction of self and the subsequent implementation of role (Harper, 2012). Semi-structured interviews were undertaken between November 2020 and April 2021 with thirty participants. Participants were purposively sampled in two stages from those who had provided email addresses during the survey stage. Participants were sorted according to their highest score on the social identification scale ('mental health worker', 'mental health social worker' or 'social worker') with an additional category for those who had scored equally highly on two or more of the three options. From within these subsets, participants were selected to represent a range in terms of age, gender, ethnic background, time qualified, employer and workplace. Sampling took place over two stages in November 2020 and January 2021, with a total of 53 participants approached. Of these, 30 participants took part in an interview, 6 declined or withdrew before taking part in the interview and 17 did not respond to the invitation.

This structured approach to sampling enabled a range of views (Peters, 2010) without sacrificing the analytic depth needed to explore complex social ideas around role (Orford, 1996). Initial research design intended interviews at 10% of the survey sample size, positioning the total intended number at the higher end of normal expectations for qualitative research design (Onwuegbuzie and Collins, 2007) and beyond that expected for interviews as a data collection method (Guest et al, 2006). However, the complex nature of the sampling framework, detailing high variability in practice contexts, combined with the central intention of the research to identify central themes which applied across this

variation, necessitated a maximum variation sampling approach (Ritchie et al, 2003a) with an aim of achieving data saturation (Onwuegbuzie and Collins, 2007).

Qualitative interviewing enables depth (Hakim, 2000) and engagement with subjective meaning (O'Connell Layder and Davidson, 1994). Such subjectivity was in fitting with the study's focus on mental health social worker perspectives, focusing on a social rather than an objective experience of reality (Burgess, 1984). The focus on perspectives as an end in themselves was ideally suited to a qualitative approach (Bryman, 1988), with the researcher's knowledge of the context and field allowing for full exploration of ideas with due regard for significant issues (Noaks and Wincup, 2004).

While the comparative nature of the study might have indicated focus groups as more suitable for exploring and developing diverse perspectives on role (Finch and Lewis, 2003), two key considerations favoured interviews as an approach. The first consideration was in ensuring freedom to express contentious views without fear of recrimination (Peters, 2010). The focus on practice context required participants to be able to speak both positively and negatively about their experience of their workplace. This may have been difficult to achieve in a focus group context, especially where group membership could not be vetted for pre-existing professional relationships. The second consideration was logistical, acknowledging the challenge and exclusionary potential in trying to organise a focus group with professionals working across a national context (Frith and Gleeson, 2012). The onset of the coronavirus pandemic and the move to online settings complicated rather than simplified this; although focus groups can be undertaken effectively in online contexts (Kenny, 2005; Oringderff, 2004) access challenges combined with the time demands levelled on participants during the coronavirus pandemic indicated this would be impractical to facilitate.

Interviews were undertaken remotely via telephone or remote conferencing and were planned to last for approximately one hour, to ensure sufficient time for rapport building (O'Connell Davidson and Layder, 1994) without becoming overly burdensome (Arksey and Knight, 1999). In practice, interviews lasted between 40 and 150 minutes, although the majority were completed within 50-70 minutes. To ensure fluid discussion and maintain

focus on participants (Noaks and Wincup, 2004), interviews were audio recorded, with transcriptions produced not sooner than two weeks after completion of the interview. While best practice suggests that interviews should be transcribed within two days (Gillham, 2005), this delayed approach was adopted to ensure that the researcher experienced minimal influence from the participants views over the period during which participants could still choose to withdraw, reflecting that familiarisation and transcription form the initial steps of the data analysis process (Ritchie et al, 2003b).

An interview topic guide was used to enable inclusive structure and consistency without compromising depth and flexibility (Arthur and Nazroo, 2003). This was developed with reference to both the preliminary findings from the survey and the wider literature to ensure that interviews remained focused in detail and relevance (Rubin and Rubin, 1995). Aspects drawn from the survey were around the factors which survey participants scored as more heavily influencing practice (primarily: values, roles, education and training, skills and team). These were framed in the context of discussing each individual participants role within their respective organisations in order to enable the diversity of their experiences to be explored and to minimise the extent to which specific focused questions might 'lead' participants to a particular answer (O'Connell Davidson and Layder, 1994). Key questions were contextualised to individual participants, rooting the discussion within their specific experiences, while follow up questions transitioned individual experiences into the broader context (Rubin and Rubin, 1995). Linking to the responses from the PES-NWI and COCB, organisational structures, their influence and interaction were explored in depth. However, the range of topics was kept to a minimum to allow for depth without becoming overwhelming and the aim was to use the survey findings in a targeted rather than a comprehensive way. Participants were informed of the researcher's mental health social work background, both to prove worth (Arksey and Knight, 1999) and to establish shared understanding.

## 6.5 Data Analysis

### 6.5.1 Analysis of the survey

Statistical analysis of the survey data was undertaken using SPSS version 27. Due to the intention that the findings from the survey would inform data collection at interview stage, this analysis was undertaken following closure of the survey in October 2020.

The statistical analysis aimed to explore three key areas:

1. Whether contextual or demographic characteristics were significantly associated with participant identity scores
2. Whether views on factors influencing identity differed based on aspects of practice context
3. Where scores on the practice rating scales and their associated subscales differed based on aspects of practice context.

For the purposes of analysis, demographic characteristics were defined as age, gender, ethnicity, time qualified and time in mental health. Contextual characteristics were defined as employer (who the participant was directly employed by), workplace (where the participant spent their workdays) and management (who the participant's immediate manager was directly employed by).

The categorical and ordinal nature of the data collected necessitated nonparametric analysis (Salkind, 2014). Chi square tests of independence were used to investigate associations between the characteristics as detailed and participant identity scores (Franke et al, 2011). Assumptions of case independence were met; assumptions of expected frequency were not but this was addressed through application of the Fisher-Freeman-Halton Exact Test for RxC tables (Freeman and Halton, 1951). In order to enable exact computations to be undertaken, characteristic variables were recoded to reduce individual cell counts (Field, 2013). Reflecting that Chi square tests of independence do not measure strength of association, Cramer's V tests were included for this purpose, as all variables continued to contain more than two categories (Field, 2013).

Kruskel-Wallis H-tests were undertaken to explore group differences between responses to the factors influencing identity question, the PES-NWI (Lake, 2007) and the Culture of Care

Barometer (Rafferty et al, 2015). The Kruskel-Wallis H-test is a nonparametric one-way analysis of variance comparing overall differences between two independent samples (Salkind, 2014). Visual inspection of boxplots identified dissimilar distribution across the variables and therefore the limited rank mean Kruskel-Wallis H-test was undertaken in all cases. The Kruskal-Wallis H-test establishes significant differences between the groups but cannot be used to identify which sample pairs are different (Corder and Foreman, 2009). All pairs of groups were therefore compared using a post-hoc pairwise comparison (Field, 2013) to establish specifically where group differences for each set of variables had occurred. Comparisons were undertaken using Dunn's (1964) procedure with a Bonferroni correction (Dinno, 2015) to protect against Type I statistical errors arising from multiple tests (Corder and Foreman, 2009).

### 6.5.2 Analysis of the interviews

Qualitative analysis of the interview data was undertaken inductively using the Framework Thematic Model (Ritchie et al, 2003b). The Framework model represents a systematic and structured approach to thematic analysis to facilitate rigorous data management (Ritchie et al, 2003b), relying on a matrix structure to manage large amounts of data (Gale et al, 2013; Good and Watts, 1996). Critically for this study, the matrix approach maintains the link between raw data and interpretation, enabling the researcher to both compare across and within cases, in turn maintaining the centrality of the context of the data (Hackett and Strickland, 2019) and facilitating a comparative approach to data analysis (Gale et al, 2013).

The Framework model sets out a five-stage approach to analysis as follows:

1. Familiarisation
2. Constructing the thematic framework
3. Indexing and sorting
4. Summary and display
5. Mapping and interpretation

(adapted from Hackett and Strickland, 2019)

Familiarisation requires an immersive approach to the raw data, with the objective of building a "conceptual scaffolding" (Ritchie et al, 2003b, p. 221) upon which to construct the thematic framework. Familiarisation began while data collection was ongoing both to enable verification of emerging ideas in the subsequent interviews and to address any issues within the topic guide (Noaks and Wincup, 2004). Familiarisation therefore was undertaken with a selected subset of the transcripts. This is a standard approach for use in the Framework model, which acknowledges that extensive familiarisation is both resource heavy, but potentially also unnecessary depending on the level of involvement the researcher held in data collection and transcription (Ritchie et al, 2003b).

Recurring themes were noted during the familiarisation process to inform the development of the thematic framework. The framework drew on both existing conceptual ideas drawn from the literature and the earlier stages of the study, and on emergent ideas arising within the data (Ritchie et al, 2003b). Acknowledging the complexity of the topic under discussion, a fluid approach to application was adopted, with the thematic index undergoing revision as part of the process (Ritchie et al, 2003b), ensuring that the index remained responsive to rather than being imposed upon the data.

Indexing was undertaken in situ within the original transcripts, with data subsequently summarised into thematic charts. Participant identifiers were retained to maintain the raw data links (Ritchie et al, 2003b) while content was also colour coded for employment context making use of the visual representation of the data to aid interpretation (Coffey and Atkinson, 1996). Colour coding followed the following structure

1. Local authority participant in local authority team
2. Local authority participant in co-located NHS team
3. Local authority participant in integrated NHS team
4. NHS participant in local authority team
5. NHS participant in NHS team
6. Third sector participant

The dataset was subsequently explored in depth to identify, categorise and classify aspects of the social work professional role and wider impacting factors, while also interrogating for contextual similarities and differences related to employment context (Ritchie et al, 2003b). Framework analysis has been criticised as lacking analytic depth (Peters, 2010) and coping poorly with complex heterogeneous data (Gale et al, 2013). However, structured immersion in the data enabled explanations to be rooted within participant narratives (Ritchie et al, 2003b). Although the act of summarising for the thematic framework arguably divorces the researcher from the participant's presentation of reality, the act of summarising in itself necessitates close engagement with the raw data to ensure that relevant detail is captured (Ritchie et al, 2003b), thereby rooting the reality of the analysis within the subjective experience of the participant (Ramazanoglu and Holland, 2002).

Sole researchers enable continuity (Thomson and Holland, 2003), while simultaneously increasing the risk of bias within interpretation (Rutter, 2006). The researcher used a combination of academic supervision (Dickson-Swift et al, 2007), anonymised independent researcher discussion, drawing on ideas of investigator triangulation and reflective supervision within the limitations of the study, and participant feedback on preliminary findings (Kalof et al, 2008) to ensure the research remained credible and to counteract the effects of individual bias.

## 6.6 Ethical scrutiny

Ethical approval for this stage of the study was obtained from the University of York in a two-stage process, with initial approval supplemented by later approval of the interview topic guide following completion of the survey stage. The need for HRA ethical approval for research within the NHS was difficult to establish, and a full application was made. This subsequently identified that although the study did classify as research, it did not require management from within the NHS and therefore did not require HRA oversight (Health Research Authority, 2019).

Ethical considerations extend beyond formal approval processes, however (Sin, 2005). Ethics are an ongoing consideration within any research study, and are contingent upon

changing contexts, meaning in turn that ethical decision-making is both continual and contextual (Mason, 2002). Key ethical decisions that arose in the completion of this study related to the ethics of collecting data in the context of the coronavirus pandemic, and the issue of participant anonymity.

Undertaking public sector research in the context of a global health emergency is challenging. Not only is it critical to ensure that research is both scientifically valid and of social value, it must also be the case that research does not impede responses to the crisis situation (World Health Organisation, 2020). Research with health and social care staff and organisations needs to consider not only its relevance, but the extent of the burden it places on prospective participants and their organisations at points where care needs to be prioritised (Bierer et al, 2020). In addition, researchers need to consider the wider-ranging impacts of the pandemic; while professional health and social care participants would not normally be classed as vulnerable, distress is likely to be higher in the context of the pandemic effects (Townsend et al, 2020), with impacts felt economically, socially and psychologically across the general population (Buckle, 2021) and disproportionately affecting those working 'on the front line' (House of Commons Health and Social Care Committee, 2020).

The WHO (2020) suggest that in these circumstances, methodological orthodoxy should be replaced by a critical consideration of the research context to inform best research practice decisions. While a full exploration of the research paradigm debate is beyond the scope of this thesis (see, for example, Christie and Fleischer, 2015; Silverman, 1998; Hammersley, 1995) this study, in line with other mixed methods approaches, was conceptualised from a pragmatic paradigm, focused upon research decision-making rooted in the anticipated practical consequences (Burke Johnson and Onwuegbuzie, 2004). This stance is rooted in the perspective that research methods in themselves do not carry epistemological and ontological commitments (Bryman, 2012) with both objective and subjective interpretations holding validity dependent upon context (Christie and Fleisher, 2015). Method use arises from the question to be addressed, rather than being rooted within particular perceptions of the nature of knowledge and reality (Bryman, 1988) and the use of methodological

pluralism combined with data pluralism serves as a triangulation technique to improve validity (Olsen, 2004).

This stance enabled fluidity in the application of the study methods, with approaches to recruitment and data collection adapted to minimise both the burden on health and social care organisations already under pressure and the risks to potential participants, particularly in terms of health. Targeted recruitment which placed a higher burden on organisations was sacrificed in favour of a more widespread but less discriminate approach. While it is important to be aware of the potential implications within the pandemic context of changes for the validity of research findings (Townsend et al, 2020; World Health Organisation, 2020) the broader footprint of survey recruitment was balanced by a richer and more diverse sample pool for interview recruitment, enabling recruitment of a range of participants who represented closer to the full range of practice contexts than the targeted sample would have allowed.

Preserving participant anonymity was highlighted as a potential concern during the interview stage of data collection. Participant accounts were rich and detailed and, as necessitated by the research question, heavily context dependant. While meticulous data cleaning was undertaken to anonymise personal, organisational and geographical identifiers (Saunders et al, 2015) during the transcription and pseudonymisation stage, it was not possible to remove contextual identifying details without markedly altering participant accounts (Saunders et al, 2015; Kaiser, 2009). Participant accounts were often unique in terms of job role, team remit or service structure, such that they would be identifiable through a process of "deductive disclosure" (Kaiser, 2009, p. 1632), whereby a participant can be identified by those familiar with their personal, or in this case, professional circumstances.

Tolich (2004) distinguishes between external and internal confidentiality, with the former relating to protection of confidentiality from outsiders, and the latter protection from insiders. He suggests that internal confidentiality issues present particular issues for outsider researchers in identifying the nuances of a situation which may lead to inadvertent harm. This dilemma is not new for qualitative researchers, who often face the dilemma of

whether to include or exclude information on the basis of harmful content (Goodwin et al, 2003), to maintain participant privacy from professionals (Kaiser, 2009) or to prevent negative consequences in employment contexts (Baez, 2002). This latter is particularly relevant in the context of the current study and necessitated a consideration of how internal confidentiality will be addressed.

The significance of context to this study suggests that the removal of contextual detail would detrimentally impact on the capability of the study to answer its own research question, which in itself has ethical implications in terms of participant time and investment. However, protecting participant confidentiality, and correspondingly their professional reputation took precedence. Following the initial pseudonymisation, therefore, extracts intended for inclusion in the thesis underwent a second anonymisation review (Saunders et al, 2015) to ensure that any identifying details had been removed. In addition, rather than assigning each participant an individual pseudonym within the thesis, participant quotes are grouped according to employment context, reflecting an approach adopted successfully in a previous, smaller scale study (Tucker and Webber, 2021). While neither of these strategies can guarantee internal confidentiality, the aim was to provide a sufficient level of obfuscation as to identity while retaining the participants core messages. This was intended to ensure that protecting participants did not equate to silencing their narratives.

## 6.7 The researcher in context

Scientific constructions of the social world risk ignoring the influence of the researcher in undertaking this construction (Adkins, 2002). In the context of undertaking research with professionals, the researcher held the privileged position of being both a qualified and registered social worker and of having previous experience of working within secondary mental health services. This information was not withheld from participants but was also not centralised. While shared professional experience can be valuable in both establishing researcher credentials and facilitating communication and access (Robson, 2011; Hornsby-Smith, 1993), it also potentially leads to presumptions of shared understanding, which can limit opportunities for clarification (Gregor, 2010). Professional ways of talking risk participants inferring 'desirable' answers from the approach to questioning (Shipman, 1997)

and where participants assume a shared understanding with the researcher, there is a risk that demonstrating a perceived lack of this through 'obvious' questioning can devalue the worth of the researcher, and by extension the research itself (Rubin and Rubin, 1995).

Critically, however, this research necessitated an overt awareness of the researchers' preconceived ideas relating to mental health social work, drawn from previous practice and research experience. These preconceptions had the potential to impact on the researcher's understanding of participant narratives, in addition to how these were subsequently interpreted. This challenge is inherent to undertaking research within contexts where the researchers are "conscious participants" (Engel and Schutt, 2014, p.4), rooted in experience within the social reality under investigation.

To address this, the researcher drew upon existing practice skills and strategies previously adopted during research with social work professionals. Initial reflection on interviews was supplemented by an informal review of interview questioning techniques following each session, with interview reflections relating to the researcher's use of interview skills discussed anonymously with an independent social researcher at regular intervals throughout the data collection process. Interpretation and associated meaning were discussed with the thesis supervisors and presented and defended to peers within the academic context. Interviewing was positioned as an active activity, necessitating practice skills in active listening (Kalof et al, 2008).

While these reflexive approaches help to minimise undue researcher influence (Kalof et al, 2008), external means of validation were also incorporated into the research design. The use of audio-recording de-emphasised reliance on the interpretive nature of field notes, enabling the researcher to challenge and question potential confirmation bias and status quo adherence (Engel and Schutt, 2014). Further validation was sought through the participant feedback on initial findings. This enabled reflexive challenge of the researcher's preconceptions where participant feedback contradicted the 'authoritative' researcher interpretations of the data (Adkins, 2002), thereby measuring interpretations against the participants' lived experience of practice reality.

# Chapter 7 - Results: A social survey of mental health social workers' perspectives on professional identity and employment context

The survey of mental health social workers set out to explore participants' views on their professional identity, factors that influenced this and their views on their interactions with different aspects of their workplace contexts, while allowing a consideration of how this varied based on employment status and practice setting. This aimed to address in part the questions around how mental health social workers understood their role within mental health and how the context of their practice influenced this. While the survey could not and did not intend to address these questions in full, the analysis aimed to explore the relationship between participants' perspectives on their role and the influence of their organisational perspective, both to gather insights in their own right and to help inform the subsequent in-depth explorations during the interview stage.

Having established the parameters of the survey and characteristics of the participants, both personally and in their professional setting, this chapter explores the findings on how participants categorise their mental health social work identity in line with McCrae et al's (2004) genericist-eclecticist-traditionalist typology before moving on to explore the significance of influencing factors on sense of identity. The relationship with the practice environment is then elucidated using the findings from the two workplace environment tools: the Practice Environment Scale – Nursing Work Index and the Culture of Care Barometer. For each aspect of the analysis, in keeping with the research focus on establishing both commonality and context driven difference, overall findings for the participants as a single group are compared against those for participant subgroups defined on the basis of different aspects of employment status.

## 7.1 Participant characteristics

Survey responses were gathered between April and October 2020. 248 participants completed the full survey, with partial responses not recorded in the final dataset.

Participants were aged between 23 and 69. Approximately three-quarters identified as female, by comparison to 80% female – 20% male for the profession across all sectors (Skills for Care, 2017; Turner, 2016), meaning that male participants were slightly over-represented against the social work workforce overall, although data is unavailable for comparison to the mental health social work workforce specifically. White participants were also over-represented in comparison to the general population and the NHS workforce (NHS Benchmarking, 2020), and to the adult social care social work workforce (Skills for Care, 2017). Full demographic details are reported in Table 7.1.

| | *Demographic Category* | *Total n (percentage)* |
|---|---|---|
| *Participant age group* | 20-29 | 31 (12.5%) |
| | 30-39 | 62 (25.0%) |
| | 40-49 | 69 (27.8%) |
| | 50-59 | 60 (24.2%) |
| | 60-69 | 22 (8.9%) |
| | Not answered | 4 (1.6%) |
| | | |
| *Participant gender* | Male | 56 (22.6%) |
| | Female | 187 (75.4%) |
| | Prefer to self-describe | 2 (0.8%) |
| | Not answered | 3 (1.2%) |
| | | |
| *Participant ethnicity* | White British | 213 (85.9%) |
| | White Irish | 5 (2.0%) |
| | White Other | 10 (4.0%) |
| | Mixed White and Black Caribbean | 1 (0.4%) |
| | Mixed White and Asian | 3 (1.2%) |
| | Mixed Other | 2 (0.8%) |
| | Asian Indian | 2 (0.8%) |
| | Asian Pakistani | 2 (0.8%) |
| | Black African | 2 (0.8%) |

| | | |
|---|---|---|
| | Black Caribbean | 5 (2.0%) |
| | Black Other | 1 (0.4%) |
| | Not answered | 2 (0.8%) |

Table 7.1: Survey participant demographic information

Participant social work experience ranged from minimal to extensive, with 52.5% of participants reporting more than ten years experience as a qualified social worker, in line with the national average for the adult social care sector (Skills for Care, 2020b). Mental health experience similarly ranged from relatively inexperienced to extensively experienced in mental health, with 43.1% of participants having more than ten years experience in mental health settings (Table 7.2).

Participants also had experience in a range of work environments. NHS based experience was the most common, with almost two-thirds of participants having worked in this context. Least common was in the third sector, with only 7.3% of participants having worked in these environments. Participants also reported experience of practice in other self-defined contexts: Community Interest Companies (0.8%, n=2), Social Enterprises (0.8%, n=2), Probation (0.8%, n=2), jointly managed statutory teams (0.8%, n=2), residential settings (0.4%, n=1) and academic support services (0.4%, n=1) (Table 7.3).

| | *Duration* | *Total n (percentage)* |
|---|---|---|
| *Time Qualified* | Less than 6 months | 4 (1.6%) |
| | 6 months to 2 years | 24 (9.7%) |
| | 2 years to 5 years | 44 (17.7%) |
| | 5 years to 10 years | 44 (17.7%) |
| | 11 years to 20 years | 79 (31.9%) |
| | More than 20 years | 51 (20.6%) |
| | Not answered | 2 (0.8%) |
| | | |
| *Time in Mental Health* | Less than 6 months | 4 (1.6%) |
| | 6 months to 2 years | 44 (17.7%) |

| | | |
|---|---|---|
| | 2 years to 5 years | 57 (23.0%) |
| | 5 years to 10 years | 33 (13.3%) |
| | 11 years to 20 years | 62 (25.0%) |
| | More than 20 years | 45 (18.1%) |
| | Not answered | 3 (1.2%) |

Table 7.2: Survey participant social work and mental health experience

| *Working Context* | *Total n (percentage)* |
|---|---|
| NHS-managed team at NHS base | 158 (63.7%) |
| Local Authority-managed team at NHS base | 141 (56.9%) |
| Local Authority-managed team at Local Authority base | 139 (56.0%) |
| NHS-managed team at Local Authority base | 21 (8.5%) |
| Third Sector Team | 18 (7.3%) |
| Private Sector Team | 34 (13.7%) |
| Other | 13 (5.2%) |

Table 7.3: Survey participant previous working experiences

## 7.2 Participant current working contexts

Participants were predominantly employed by local authorities, with the second most common employer the NHS. These two statutory employers accounted for 94% of participants. Other employers were identified as joint statutory employment (1.6%, n=4), Community Interest Companies (0.8%, n=2), Social Enterprises (1.2%, n=3), and academic support services (0.4%, n=1), reflecting that most elements of participants' wider experience was contemporary (Table 7.4).

Although local authorities employed over two thirds of participants, less than one quarter worked in local authority settings (22.2%, n=55). The majority of participants worked within the NHS; 71.7% (n=178) of participants were based within NHS teams. 51.6% (n=128) of

participants were employed with local authority line management, while 42.3% (n=105) of participants were managed by NHS staff (Table 7.5).

| *Current Employer* | *Total n (percentage)* |
|---|---|
| NHS Trust | 60 (24.2%) |
| Local Authority | 173 (69.8%) |
| Private Sector Organisation | 1 (0.4%) |
| Third Sector Organisation | 1 (0.4%) |
| Other | 11 (4.4%) |
| Not answered | 2 (0.8%) |

Table 7.4: Survey participant current employer

| *Current workplace* | *Total n (percentage)* |
|---|---|
| NHS-managed team at NHS base | 104 (41.9%) |
| Local Authority-managed team at NHS base | 74 (29.8%) |
| Local Authority-managed team at Local Authority base | 54 (21.8%) |
| NHS-managed team at Local Authority base | 1 (0.4%) |
| Third Sector Team | 1 (0.4%) |
| Private Sector Team | 1 (0.4%) |
| Other | 10 (4.0%) |
| Not answered | 3 (1.2%) |

Table 7.5: Survey participant current workplace

## 7.3 Establishing mental health social work identity

Identity was ranked on a Single-Item Social Identification (SISI) measure (Postmes et al, 2013), with participants asked to rank on a scale of one to seven how closely they identified with the professional groups of 'social worker', 'mental health worker' and 'mental health social worker'. Participants identified strongly with all three scales of professional identity. Participants identified most strongly with 'mental health social worker' (mean=6.13,

missing=1), followed by 'social worker' (mean=5.65, missing=2), with 'mental health worker' scoring weakest (mean=5.32, missing=3). Acknowledging the ordinal nature of the data collected, other measures of central tendency were checked and followed a similar pattern, with 'mental health social worker' scoring most strongly (median=7), followed by 'social worker' (median=6) and 'mental health worker' (median=5).

A fourth scale also measured the importance of professional identity. Participants viewed professional identity as highly important (mean=6.27, median=7, missing=3). Professional identity was also seen as distinctly separate from personal identity, with 76.6% (n=190) rating this as different to some extent. Only one in twenty participants (5.2%, n=13) viewed personal and professional identity as indistinct from one another. Almost all participants held a view on this, with only 1.6% (n=4) recording an answer of unsure, and 0.4% (n=1) recording no answer (Table 7.6).

| *Identity Scale* | *Mean* | *Standard Deviation* | *Median* |
|---|---|---|---|
| I identity with social workers | 5.65 | 1.39 | 6 |
| I identify with mental health workers | 5.32 | 1.40 | 5 |
| I identity with mental health social workers | 6.13 | 1.30 | 7 |
| My professional identity is important to me | 6.27 | 1.16 | 7 |

Table 7.6: Survey participant views of social identity on the SISI

Participants did not view the three categories of identity as mutually exclusive. Scoring highly in one aspect did not preclude participants from scoring highly in others; 14.9% of participants (n=36) scored all three social identification categories at the maximum 7, while a further 6.5% (n=15) scored two categories at 7 and one at 6. Conversely, the rejection of these identities was not mirrored; there were no participants who scored all three categories at the minimum 1, while only 0.4% (n=1) scored two categories at 1, and one category at 2.

## 7.4 Understanding mental health social work identity

Chi square tests of independence were run to determine whether the demographic or contextual characteristics associated with scores on the identity scales overall and to establish the strength of any associations (Table 7.7).

| | *Social Worker* | | | | *Mental Health Worker* | | | |
|---|---|---|---|---|---|---|---|---|
| | $X^2$ | *df* | *p* | *V* | $X^2$ | *df* | *p* | *V* |
| *Age* | 2.731 | 8 | .950 | .075 | 14.039 | 8 | .081 | .170 |
| *Gender* | 1.035 | 2 | .596 | .065 | 5.694 | 2 | .058 | .154 |
| *Ethnicity* | 2.766 | 2 | .251 | .106 | .140 | 2 | .932 | .024 |
| *Time qualified* | 1.308 | 8 | .995 | .052 | 12.190 | 8 | .143 | .158 |
| *Time in MH* | 9.323 | 8 | .316 | .138 | 25.458 | 8 | .001** | .229 |
| *Employer* | .304 | 4 | .990 | .025 | 4.908 | 4 | .297 | .100 |
| *Management* | 3.901 | 4 | .420 | .089 | 4.497 | 4 | .343 | .096 |
| *Workplace* | 2.556 | 4 | .635 | .072 | 2.559 | 4 | .634 | .073 |

| | *Mental Health Social Worker* | | | | *Importance of Identity* | | | |
|---|---|---|---|---|---|---|---|---|
| | $X^2$ | *Df* | *p* | *V* | $X^2$ | *df* | *p* | *V* |
| *Age* | 11.197 | 8 | .191 | .151 | 8.805 | 8 | .359 | .135 |
| *Gender* | 2.427 | 2 | .215 | .100 | 1.921 | 2 | .383 | .089 |
| *Ethnicity* | 4.645 | 2 | .098 | .137 | 1.548 | 2 | .461 | .080 |
| *Time qualified* | 17.302 | 8 | .027* | .188 | 10.672 | 8 | .221 | .148 |
| *Time in MH* | 11.747 | 8 | .163 | .155 | 8.241 | 8 | .410 | .130 |
| *Employer* | 2.216 | 4 | .713 | .066 | 5.734 | 4 | .220 | .108 |
| *Management* | 1.423 | 4 | .840 | .054 | 6.919 | 4 | .140 | .119 |
| *Workplace* | 2.558 | 4 | .634 | .072 | 1.339 | 4 | .855 | .872 |

Table 7.7: Chi square tests of independence for survey participant identity scores against demographic and contextual factors

*p<0.05, **p<0.01, ***p<0.001

Demographic factors relating to the individual and workplace contextual factors showed no significant association with identity scores or the extent to which participants valued their social work identity. There was a statistically significant association between time qualified and the mental health social work identity. Assessed according to Cohen's (1988) classification of association strength, this association was small-to-moderate. Similarly, there was a moderate association observed between time spent in mental health and the mental health worker identity, although these results must be treated with some caution due to the possibility of error arising from the necessity to undertake repeated testing. Ordinal logistic regression to test the relationship and influence of these factors was not possible, due to a failure to meet the assumption of proportional odds.

Scores on the identity scales were visually inspected for differences based on employment contexts (Table 7.8).

| | | *Social Worker* | *Mental Health Worker* | *Mental Health Social Worker* | *Importance of Identity* |
|---|---|---|---|---|---|
| ***Overall*** | | **5.65** | **5.32** | **6.13** | **6.27** |
| *Current employer* | *NHS* | 5.50 (-0.15) | 5.60 (+0.28) | 6.05 (-0.08) | 6.00 (-0.27) |
| | *LA* | 5.68 (+0.03) | 5.23 (-0.09) | 6.17 (+0.04) | 6.36 (+0.09) |
| | *Other* | 5.85 (+0.20) | 5.46 (+0.14) | 6.31 (+0.18) | 6.31 (+0.04) |
| *Current Manager* | *NHS* | 5.37 (-0.28) | 5.49 (+0.17) | 6.10 (-0.03) | 6.09 (-0.18) |
| | *LA* | 5.83 (+0.18) | 5.20 (-0.12) | 6.19 (+0.06) | 6.41 (+0.14) |
| | *Other* | 5.92 (+0.27) | 5.25 (-0.07) | 6.08 (-0.05) | 6.25 (-0.02) |
| *Current base* | *NHS* | 5.51 (-0.14)* | 5.35 (+0.03) | 6.17 (+0.04) | 6.23 (-0.04) |
| | *LA* | 6.00 (+0.35)* | 5.25 (-0.07) | 6.05 (-0.08) | 6.38 (+0.11) |

| | | | | | |
|---|---|---|---|---|---|
| | *Other* | 5.92 (+0.27) | 5.25 (-0.07) | 6.08 (+0.05) | 6.25 (-0.02) |

Table 7.8: Mean Identity Scores showing differences based on employment context characteristics

*Statistically significant differences identified in the Kruskal-Wallis H test (below)

Kruskal-Wallis H tests were run to determine if there were differences in identity scores between three groups of participants, based on three different aspects of employment context. Participants were grouped on the basis of employer, workplace and management type. For each of these groupings, participants were divided into the organisational groups of "NHS", "Local Authority" and "Other". For sets based on employer and management type, there were no statistically significant differences between groups, and the null hypothesis of no group difference was retained.

For workplace, differences were identified for the social worker identity scale. There were no statistically significant differences for the other identity scales. Distributions of social worker identity scores were not similar for all groups, as assessed by visual inspection of a boxplot. The mean ranks of social worker identity scores were statistically significantly different between groups ($x^2$=6.540, df=2, p=.038).

Pairwise comparisons were performed using Dunn's (1964) procedure with a Bonferroni correction for multiple comparisons. Adjusted *p*-values are presented. Values are mean ranks unless otherwise stated. This post hoc analysis revealed statistically significant differences in social worker identity scores between the NHS (115.67) and Local Authority (141.37) groups (p=.043), but not for any other group combination. In this aspect of social worker identity, Local Authority social workers scored more highly than NHS social workers.

## 7.5 Factors influencing mental health social work identity

228 participants undertook the ranking exercise prioritising factors which influenced professional identity (missing=20) from the following list:

- Social work education and training (Education)

- Nature and requirements of work role (Role)
- Using social work specific skills (SW Skills)
- Being part of a team with social workers (SW Team)
- Working with social work theories and interventions (SW Theories)
- Working within a social work value base (Values)
- Belonging to a professional organisation (Prof Organisation)
- Working with professional standards of conduct (Prof Standards)
- The ethos of the organisation they work within (Org Ethos)
- Working to a professional code of ethics (Prof Ethics)
- Public perceptions of social work (Perceptions)

Participants showed a high level of variability in these rankings. The factor scored most consistently as having the most influence on professional identity was the social work value base (31.5%, n=78); the factor scoring most consistently as having the least influence on professional identity was public perceptions of social work (60.1%, n=149).

A model representing overall trends within the participants was constructed using the sample mean score for each factor, based on its positioning within the list across the sample (Table 7.9). Comparison sets based on employer, workplace and manager type were also produced for visual exploration of differences between the employment groups. These appeared broadly similar, although job role generally ranked more highly for local authority social workers than those in NHS or other settings, while working with social work theories and being part of a social work team were overall of less importance to those in other settings than statutory (Tables 7.10-7.12).

| *Factors influencing professional identity* | *Sample mean (standard deviation)* |
|---|---|
| 1. Values | 3.08 (±2.22) |
| 2. Role | 4.11 (±2.42) |
| 3. Education | 4.16 (±2.72) |
| 4. SW Skills | 4.29 (±2.05) |
| 5. SW Team | 5.29 (±2.79) |

| | |
|---|---|
| 6. SW Theories | 6.06 (±2.34) |
| 7. Prof Ethics | 6.35 (±2.85) |
| 8. Prof Standards | 6.54 (±2.47) |
| 9. Org Ethos | 7.79 (±2.70) |
| 10. Prof Organisation | 8.29 (±2.40) |
| 11. Perceptions | 10.04 (±1.82) |

Table 7.9: Overall model for factors influencing professional identity

| **NHS** | **LA** | **Other** |
|---|---|---|
| Values (1) | Values (1) | Values (1) |
| Education (3) | Role (2) | Education (3) |
| SW Skills (4) | SW Skills (4) | SW Skills (4) |
| Role (2) | Education (3) | Role (2) |
| SW Theories (6) | SW Team (5)* | Prof Standards (8) |
| SW Team (5)* | SW Theories (6) | Prof Ethics (7) |
| Prof Ethics (7) | Prof Ethics (7) | SW Theories (6) |
| Prof Standards (8) | Prof Standards (8) | SW Team (5) |
| Prof Organisation (10) | Org Ethos (9) | Org Ethos (9) |
| Org Ethos (9) | Prof Organisation (10) | Prof Organisation (10) |
| Perceptions (11) | Perceptions (11) | Perceptions (11) |

Table 7.10: Differences in factors influencing professional identity based on employer (overall rank for each factor included in parentheses)

*Statistically significant differences identified in the Kruskal-Wallis H test (below)

| **NHS** | **LA** | **Other** |
|---|---|---|
| Values (1) | Values (1) | Values (1) |
| Role (2) | Education (3) | Education (3) |
| SW Skills (4) | Role (2) | SW Skills (4) |
| Education (3) | SW Skills (4) | Role (2) |
| SW Team (5) | SW Team (5) | Prof Standards (8) |
| SW Theories (6)* | SW Theories (6) | Prof Ethics (7) |

| | | |
|---|---|---|
| Prof Ethics (7) | Prof Ethics (7) | Org Ethos (9) |
| Prof Standards (8) | Prof Standards (8) | SW Team (5) |
| Org Ethos (9) | Org Ethos (9) | SW Theories (6)* |
| Prof Organisation (10) | Prof Organisation (10) | Prof Organisation (10) |
| Perceptions (11) | Perceptions (11) | Perceptions (11) |

Table 7.11: Differences in factors influencing professional identity based on manager (overall rank for each factor included in parentheses)

*Statistically significant differences identified in the Kruskal-Wallis H test (below)

| **NHS** | **LA** | **Other** |
|---|---|---|
| Values (1) | Values (1) | Values (1) |
| Role (2) | Education (3) | Education (3) |
| SW Skills (4) | Role (2) | SW Skills (4) |
| Education (3) | SW Skills (4) | Role (2) |
| SW Team (5) | SW Team (5) | Prof Standards (8) |
| SW Theories (6) | Prof Ethics (7) | Prof Ethics (7) |
| Prof Ethics (7) | SW Theories (6) | Org Ethos (9) |
| Prof Standards (8) | Prof Standards (8) | SW Team (5) |
| Org Ethos (9) | Org Ethos (9) | SW Theories (6) |
| Prof Organisation (10) | Prof Organisation (10) | Prof Organisation (10) |
| Perceptions (11) | Perceptions (11) | Perceptions (11) |

Table 7.12: Differences in factors influencing professional identity based on workplace (overall rank for each factor included in parentheses)

Kruskal-Wallis H tests identified no statistically significant differences between the groups based on workplace type. However, for employer type, differences were identified for the mean score for being part of a team with social workers, with distributions of the mean score not similar for all groups. The mean ranks of being part of a team with social workers mean scores were statistically significantly different between groups ($x^2$=11.038, df=2, p=.004).

Pairwise comparisons were performed, with this post hoc analysis revealing statistically significant differences in being part of a team with social workers between the NHS (132.52) and Local Authority (104.95) groups (p=.022), but not for any other group combination. This signified that NHS social workers placed a higher value on being part of a team with other social workers than their local authority counterparts.

For manager type, differences were identified for the mean scores for being part of a team with social workers, and for using social work theories and interventions. The mean ranks of being part of a team with social workers mean scores ($x^2$=7.652, df=2, p=.022), and for using social work theories and interventions ($x^2$=6.618, df=2, p=.037) were statistically significantly different between groups.

Pairwise comparisons revealed no statistically significant differences for any group combination on being part of a social work team. For using social work theories and interventions, the post hoc test revealed statistically significant differences between the NHS (105.03) and Other (157.50) groups (p=.044), but not for any other group combination, with those managed outside of NHS management structures, but not within local authorities placing significantly more importance on the use of social work theories.

## 7.6 The Practice Environment Scale – Nursing Work Index (PES-NWI)

The PES-NWI (Lake, 2002) measures the nursing practice environment, although is easily adapted to other professions and contexts, and the extent to which this facilitates professional practice across five subscales:

- Participation in Organisational Affairs
- Staffing and Resource Adequacy
- Quality of Care
- Manager leadership, ability and staff support
- Relationship with health colleagues

The composite PES-NWI mean score for all participants, equally weighted across the subscales, was 2.76 (sd=.42) against a maximum possible 4. The lowest scoring subscale was Participation (mean=2.50, sd=.59), while participants scored highest on Leadership (mean=3.00, sd=.66). Comparisons in scores were undertaken based on employer, management and workplace (Table 7.13).

| | | ***Overall Score*** | *Participation* | *Quality of Care* | *Leadership* | *Staffing and Resources* | *Health Relations* |
|---|---|---|---|---|---|---|---|
| ***Full sample (sd)*** | | **2.76** | 2.50 (.59) | 2.81 (.55) | 3.00 (.66) | 2.51 (.65) | 2.97 (.68) |
| *Current employer* | *NHS* | **2.85** | 2.59 | 2.74 | 3.05 | 2.65 | 3.22* |
| | *LA* | **2.74** | 2.47 | 2.84 | 3.00 | 2.48 | 2.90* |
| | *Other* | **2.69** | 2.61 | 2.76 | 2.87 | 2.30 | 2.86 |
| *Current Manager* | *NHS* | **2.76** | 2.42* | 2.66* | 2.90 | 2.53 | 3.21* |
| | *LA* | **2.77** | 2.54 | 2.92* | 3.07 | 2.50 | 2.82* |
| | *Other* | **2.76** | 2.86* | 2.85 | 3.08 | 2.36 | 2.61* |
| *Current base* | *NHS* | **2.81** | 2.48 | 2.78 | 3.02 | 2.56 | 3.14* |
| | *LA* | **2.62** | 2.50 | 2.89 | 2.93 | 2.36 | 2.53* |
| | *Other* | **2.76** | 2.86 | 2.85 | 3.08 | 2.36 | 2.61 |

Table 7.13: Mean PES-NWI Scores showing variation based on employment context characteristics

*Statistically significant differences identified in the Kruskal-Wallis H test (below)

These scores were overall favourable in line with Lake and Friese's (2006) three stage classification of 'favourable', 'mixed' and 'unfavourable'. In this classification, scores above the theoretical midpoint of 2.5 are deemed generally favourable, and scores below are deemed generally unfavourable. Overall scores are classified as 'favourable' if one or fewer subscales rate as unfavourable, 'mixed' if two or three rate as unfavourable and 'unfavourable' if four or five rate as unfavourable. By this measure, participants' responses

were favourable in all contexts except for those employed by local authorities, who returned a 'mixed' result, with unfavourable responses on the Participation and Staffing and Resource subscales.

Kruskal-Wallis H tests were run to determine whether there were differences in the means scores across employer, manager and workplace contexts (Table 7.14). Overall PES-NWI scores showed no statistically significant differences between groups across all contexts, and the null hypothesis of no group difference was retained.

| | ***Overall Score*** | *Participation* | *Quality of Care* | *Leadership* | *Staffing and Resources* | *Health Relations* |
|---|---|---|---|---|---|---|
| *Current employer* | **.440** | .474 | .347 | .759 | .089 | .008** |
| *Current Manager* | **.922** | .020* | .000*** | .057 | .685 | .000*** |
| *Current base* | **.052** | .093 | .278 | .758 | .147 | .000*** |

Table 7.14: Significance table for the Kruskal-Wallis H test across the five subscales of the PES-NWI, based upon employment context characteristics

*p<0.05, **p<0.01, ***p<0.001

In the health relations subscale, statistically significant differences were found across all three domains of employment context. Distributions of the mean score were visually assessed on box plots and were not similar in any context. Pairwise comparisons were performed and statistically significant mean ranks and group differences for health relations are reported in Table 7.15.

| | $x^2$ | *df* | *p* | *Group differences* | *Adj. p* |
|---|---|---|---|---|---|
| *Current employer* | 9.769 | 2 | .008 | LA (114.94) – NHS (147.32) | .006 |

| | | | | | |
|---|---|---|---|---|---|
| *Current Manager* | 22.438 | 2 | .000 | Other (90.46) – NHS (146.53)<br>LA (109.58) – NHS (146.52) | .023<br>.000 |
| *Current base* | 36.054 | 2 | .000 | LA (77.13) – NHS (138.77) | .000 |

Table 7.15: Group differences in the health relations PES-NWI subscale

NHS social workers placed more importance in health relations than their counterparts in local authorities across all aspects of employment context. They also valued health relations higher than their counterparts in other areas of practice who were managed outside of a statutory context. This is perhaps unsurprising when considering the closer proximity of NHS social workers to health colleagues than social workers employed, located and managed within other contexts.

Additional differences were found in the management domain for the participation and quality of care subscales. Distributions of the mean score were not similar in either case. The mean ranks were statistically significant for participation ($x^2$=7.805, df=2, p=.020) and quality of care ($x^2$=15.625, df=2, p=.000).

Pairwise comparisons revealed statistically significant differences in participation scores between the NHS (110.27) and Other (163.54) groups (p=.037), and in quality-of-care scores between the NHS (98.98) and Local Authority (135.23) groups (p=.000) but not for any other group combination. In the participation aspect, NHS managed social workers felt less involved than peers in other contexts, while for the quality-of-care aspect, NHS managed participants felt less influential than their local authority counterparts.

## 7.7 The Culture of Care Barometer (COCB)

The Culture of Care Barometer (Rafferty et al, 2015) measures the culture of a health working environment, in the context of staff commitment, engagement and productivity. Perspectives across the practice environment are measured across seven subscales:

- Engagement (communication and being informed)
- Empowerment (influence and being listened to)

- Leadership (management and role models)
- Values (recognition, respect and overall culture)
- Role (training and development)
- Resources (resources and time)
- Team (support from colleagues and manager)

The composite COCB mean score for all participants, weighted across the subscales, was 3.58 (sd=.73) against a maximum possible 5. The subscale scoring most poorly was resources (mean=3.00, sd=1.02), while participants scored team most highly (mean=4.13, sd=.73). Comparisons in scores were undertaken based on employer, management and workplace (Table 7.16). However, these scores were proportionally in line with scores generated during development of the COCB instrument (Rafferty et al, 2015).

| | | *Overall* | *Engagement* | *Empowerment* | *Leadership* | *Values* | *Role* | *Resources* | *Team* |
|---|---|---|---|---|---|---|---|---|---|
| ***Full sample (sd)*** | | **3.58 (.73)** | **3.49 (.89)** | **3.39 (.75)** | **3.70 (.75)** | **3.66 (.84)** | **3.62 (.97)** | **3.00 (1.02)** | **4.13 (.73)** |
| *Current employer* | *NHS* | 3.73 | 3.57 | 3.62* | 3.77 | 3.82 | 3.65 | 3.18 | 4.19 |
| | *LA* | 3.54 | 3.47 | 3.30* | 3.69 | 3.62 | 3.66 | 2.96 | 4.11 |
| | *Other* | 3.51 | 3.46 | 3.65 | 3.72 | 3.68 | 3.03 | 2.88 | 4.15 |
| *Current Manager* | *NHS* | 3.44* | 3.28* | 3.31 | 3.57* | 3.57 | 3.34* | 2.93 | 4.02 |
| | *LA* | 3.66* | 3.63* | 3.41 | 3.79* | 3.71 | 3.83* | 3.04 | 4.21 |
| | *Other* | 3.82 | 3.79 | 3.77 | 3.97 | 3.97 | 3.75 | 3.25 | 4.23 |
| *Current base* | *NHS* | 3.56 | 3.46 | 3.37 | 3.66 | 3.67 | 3.57 | 3.01 | 4.11 |
| | *LA* | 3.59 | 3.50 | 3.36 | 3.79 | 3.58 | 3.73 | 2.92 | 4.16 |
| | *Other* | 3.82 | 3.79 | 3.77 | 3.97 | 3.97 | 3.75 | 3.25 | 4.23 |

Table 7.16: Mean COCB Scores showing variation based on employment context characteristics

*Statistically significant differences identified in the Kruskal-Wallis H test (below)

Kruskal-Wallis H tests showed that overall COCB scores on the employment and workplace base domains showed no statistically significant differences between groups (Table 7.17), and the null hypothesis of no group difference was retained.

For the management domain, there was a statistically significant difference in the mean ranks of the overall COCB score across groups ($x^2$=6.507, df=2, p=.039). Distributions of scores were not similar for all groups, as assessed by visual inspection of a boxplot. Pairwise comparisons showed statistically significant differences in overall COCB scores between the NHS (103.54) and Local Authority (125.69) groups (p=.045), but not for any other group combination, indicating that local authority social workers scored more highly overall on the weighted composite COCB scale.

| | *Overall* | *Engagement* | *Empowerment* | *Leadership* | *Values* | *Role* | *Resources* | *Team* |
|---|---|---|---|---|---|---|---|---|
| *Current employer* | **.279** | .728 | .036* | .825 | .263 | .182 | .359 | .852 |
| *Current Manager* | **.039*** | .007** | .392 | .027* | .249 | .000*** | .508 | .150 |
| *Current base* | **.648** | .591 | .501 | .337 | .369 | .462 | .636 | .972 |

Table 7.17: Significance table for the Kruskal-Wallis H test across the seven subscales of the COCB, based upon employment context characteristics

*p<0.05, **p<0.01, ***p<0.001

In the workplace domain, there were no statistically significant differences between the groups, and the null hypothesis of no group differences is retained.

In the employer domain, there was a statistically significant difference in the mean ranks for the empowerment criteria ($x^2$=6.642, df=2, p=.039), with pairwise comparisons indicating statistically significant differences between the NHS (140.41) and Local Authority (114.16) groups (p=.041), but not for any other group combination, indicating that NHS social workers felt more engaged and informed than their local authority counterparts.

Three subscales in the management domain showed statistically significant differences in the mean ranks between groups: engagement, leadership, and role. Significant group differences are reported in Table 7.18.

| | *$x^2$* | *Df* | *p* | *Group differences* | *Adj. p* |
|---|---|---|---|---|---|
| *Engagement* | 9.794 | 2 | .007 | LA (133.28) – NHS (105.90) | .009 |
| *Leadership* | 7.258 | 2 | .027 | LA (129.70) – NHS (106.92) | .040 |
| *Role* | 15.714 | 2 | .000 | LA (137.70) – NHS (101.56) | .000 |

Table 7.18: Significant group differences in the management domain within the COCB subscales

Consistently, therefore, across the domains of being informed, experiencing positive management and role models, and having access to training and development to perform their role, local authority managed social workers gave more favourable scores than their NHS counterparts.

## 7.8 Conclusions

The overall picture painted in these results is unclear. While there is a high level of congruence within the results in terms of participants views and experiences, there are some clear differences demonstrated between participants in local authority, NHS and other contexts. Starting with identity, for the most part, social identification was robust against external influences, although there was a moderate association between low, moderate and high scores on the 'mental health worker' scale and time spent working in mental health. A similar, albeit weaker association was seen between the 'social worker' scale and the time participants had been qualified. While the chi square tests identified no association

between employment contexts and identity, subsequent analysis of the mean ranks did indicate that those participants working in local authority contexts were likely to score more highly on the 'social worker' identity scale than those working within the NHS.

While there were visual differences in the factor lists for those aspects impacting identity, group comparisons identified only two areas where these differences were statistically significant. Firstly, those participants employed within the NHS indicated that being on a team with social workers was more influential on their professional identity than their local authority employed counterparts. Secondly, those with management structures outside of statutory services highlighted social work theory as more influential than their NHS-managed peers.

Overall PES-NWI scores showed no difference between the groups based on employment contexts, by contrast to the COCB, where local authority managed social workers scored more highly overall than their NHS counterparts. However, when both scales were examined more closely, some discrepancies specifically in the NHS experience became apparent. Although participants employed by the NHS reported feeling more engaged and informed than their local authority counterparts, those managed within the NHS felt less involved and less influential in care decisions than those with local authority managers. Indeed, those managed within local authorities were more likely to score in questions related to being informed, positively managed and given access to training and development, suggesting a complex interplay of management and environmental influences impacting on social worker's experience of their employment context.

One area with a marked difference, however, was in health relations. These were clearly prioritised more highly by those employed within, working within or managed within NHS settings. In short, and perhaps unsurprisingly, those participants with closer connections to a health context appeared to respond accordingly with a higher emphasis on relationships across those connections.

The robust sense of identity, irrespective of external factors, and the subtle distinctions in experience of practice environment illuminate the value of the mixed method approach in

addressing the research questions posed in this study. The questions addressed here aim to identity both how the mental health social work role is perceived by those undertaking it, and how those perceptions are influenced by the practice context. While the breadth of responses enabled by the survey approach allowed an increased confidence that the findings were more universal and less a reflection of a particular practice context (Bryman, 1988), the lack of depth allowed by this approach did not permit a more in-depth exploration of the nature of either the strong sense of identity demonstrated here or the distinctions in perceptions of the external influences. Toomela (2008) argues that variables in which relate to human behaviour and reflect internal mental processes contain hidden layers of meaning that statistical testing alone cannot elucidate, underpinning the fundamental position of mixed method research which postulates that methodological pluralism enables the strengths of the differing methods to mitigate against their respective weaknesses (Cresswell and Piano Clark, 2007).

Adopting this position, the fullest understanding of the survey results could therefore only be established in the context of the findings from subsequent qualitative interviews. To this end, discussion of these findings needed to be undertaken in conjunction with the findings from the qualitative interviews and it is to these findings that the focus of this thesis now turns.

# Chapter 8 - Results: Understanding the social work role in mental health contexts

Central to the aims of the interview stage of the research was a need to elucidate an understanding of how participants articulated and categorised the distinct, strong mental health social work identity that had been apparent in the findings from the survey. These initial findings had clearly illustrated that professional identity in mental health social work was strong but also multi-faceted, with emphasis on both the mental health and social work elements of this, and prospectively on how they interacted. This initial reporting of the qualitative findings therefore aimed to expand on that understanding, with a detailed consideration of how participants conceptualised their mental health social work role, addressing the first of the two primary questions. Initially establishing the characteristics of the interview participants as a subsample of the survey participants, this chapter explores participants' perceptions of their role within a task-values-knowledge thematic framework. Central to this consideration and acknowledging the exploration of employment circumstances as influential on role, each identified role is positioned in the context of commonalities and variation across participants differing practice environments.

## 8.1 Participant characteristics

Interviews were undertaken between November 2020 and March 2021. Fifty-three participants were purposively selected from the survey respondents and invited to take part in interviews. Of these, six participants declined to take part and seventeen did not respond to the invitation. Thirty participants responded positively and took part in a single interview.

The interview participants as a whole reflected a diverse and complex group. Participants were aged between 24 and 65, reflecting a similar age breakdown to the fuller sample in the preceding survey. The majority of participants were female, reflecting the demographic make-up of social work nationally, although male participants were slightly over-represented by comparison to both the national picture (Skills for Care, 2017; Turner, 2016) and the preceding survey. Participants self-defined ethnicity, and although predominantly

White British, a range of ethnic backgrounds were represented. Gender and ethnicity breakdowns are detailed in Table 8.1.

| *Participant characteristic* | *Categories of characteristic* | *Number of participants* |
|---|---|---|
| Gender | Female | 21 |
| | Male | 9 |
| Ethnicity | White British | 19 |
| | White Welsh | 1 |
| | White British-Irish | 1 |
| | White European | 1 |
| | White Other | 3 |
| | Black | 3 |
| | Pakistani | 1 |
| | Indian | 1 |

Table 8.1: Interview participant breakdown by gender and ethnicity

Participants were based in a range of contexts, both geographically and professionally. Geographically, participants were drawn from all areas of England and Wales, except for the East of England region, with the South East most commonly represented (Table 8.2). Participants also worked in a mixture of area types; five in rural settings, ten in urban settings and the remaining fifteen in mixed urban and rural settings.

| *Region* | *Number of participants* |
|---|---|
| South East | 6 |
| London | 5 |
| South West | 5 |
| West Midlands | 4 |
| Wales | 4 |
| East Midlands | 2 |
| North West | 2 |
| Yorkshire and the Humber | 1 |

| | |
|---|---|
| North East | 1 |

Table 8.2: Interview participant breakdown by geographic area

In terms of professional contexts, two participants were both employed by and worked in third sector settings, although both provided NHS and/or local authority services: one in an integrated health and social care service and one in a health only service. Of the remaining twenty-eight participants, thirteen were employed by local authorities, thirteen by the NHS and two had dual agency contracts (Table 8.3)

| *Workplace* | *Employer* | *Number of participants* |
|---|---|---|
| Local authority | Local authority | 4 |
| | NHS | 1 |
| NHS | Local authority | 9 |
| | NHS | 12 |
| | Dual agency | 2 |
| Third sector | Third sector | 2 |

Table 8.3: Interview participant breakdown by employer and workplace

Of the NHS-based participants, four worked within co-located local authority teams that shared offices with NHS-led mental health teams but operated independently. Ten worked within teams which were formally integrated to some extent, and eight were based within non-integrated NHS teams. One further NHS employed participant worked as an individual practitioner without an associated team.

Eleven participants across all employment contexts were currently practicing as AMHPs. A further five had previous experience as an AMHP, although were not currently warranted, and three were in the process of undertaking AMHP training. The remaining nine participants had never worked as an AMHP. Participants as a group had a broad swathe of experience in terms of time spent qualified and mental health specific experience. Participants had been qualified for between four months and forty years, with mental

health experience ranging from one to thirty years. Some participants had also worked in mental health roles before qualifying as social workers.

Participants also worked in a range of different roles, with different levels of managerial experience. Twenty-five participants, the vast majority, worked in community settings, two of whom worked specifically in a forensic context. Of the remaining five participants, two worked in forensic inpatient services, and three worked in practitioner support roles. Job roles showed substantial variation; across the thirty participants, there were twenty-six different job titles, although some of the variations were relatively minor, for example, 'social worker' versus 'mental health social worker'. Nine participants held a dual-job title, such as 'social worker/AMHP' or 'care coordinator/social worker', reflecting the duality of their roles.

Participant's reasons for working in mental health contexts were also varied, but a number of recurring rationales emerged, including professional or academic interest, positive placement experiences during training, personal or family experience and an interest in the challenge of working in this context. Most participants had deliberately sought to work in mental health, with only three entering in the field due to chance.

## 8.2 Overview of the findings

Participants identified ten key roles for social work in mental health contexts, falling broadly into three categories: task-based, values-based and knowledge-based. Each category held three or four roles as follows:

**Task-based roles:**

- Organisational Agent
- Statutory Agent
- Collaborative Agent

**Values-based roles:**

- Holistic Practitioner
- Person-Centred Practitioner

Challenge Agent

Social Justice Advocate

**Knowledge-based roles:**

Knowledge Specialist

Educator

Discourse Challenger

Task-based roles linked to *what* participants did, while values-based roles focused more on *how* work was undertaken. Knowledge-based roles by contrast drew on aspects of social work that focused on the underpinning knowledge base for the profession, particularly where this differed from other professions within the mental health sphere.

## 8.3 Understanding mental health social work in context: the task-based role(s)

### 8.3.1 The Organisational Agent

All participants spoke about their role in the context of the work they were specifically employed by their organisations to undertake. These narratives were universally process and procedure based; as organisational agents participants, regardless of substantive role, detailed their day-to-day work within a framework of daily tasks and responsibilities, which were often linked directly to the context of practice. This was often presented, as below, as a list of responsibilities that the participant saw as integral to their practical contribution within the team.

*"Carry a caseload of people – I work within a secondary service – so a caseload of people with severe and enduring mental health problems. And I take part in the duty rotas and part in the assessment: assessing, gatekeeping, discharging"*

LA participant (Integrated NHS team)

Organisational roles fell broadly into three categories: participants worked as gatekeepers and facilitators, service providers and structural facilitators. In the gatekeeping and facilitation role, participant tasks were focused around assessment, brokerage and referral

activities. These tasks linked specifically to securing access to services, whether within the participants team or externally. Attitudes on work of this nature were mixed; for some participants, this was *"predominantly a social work job"* (LA participant, integrated NHS team), while others expressed concerns around the lack of space to work with clients in a relational way. For one participant in particular, the shift of mental health social work from *"a progressive force for change within communities…[to]…bureaucratic risk and budget protectors"* (LA participant, integrated NHS team) represented the same real discord between social work narratives and social work realities as previously reflected in research (Higgins et al, 2016).

Gatekeeping and facilitation work represented two sides of the same process. On the one hand, participants managed referrals to and assessments for access to their own services, on the other, they also sought to undertake referrals to other agencies, both internal and external. This work was presented as both bureaucratic and complex, ranging from a need to *"just monitor, sort of go through all the referrals from GPs and other people"* (LA participant, integrated NHS team) through to managing and addressing the issues arising in very complex situations in order to facilitate ongoing support, as this participant describes:

*"you'd think that'd be a lot more straightforward getting the person the level of care provision they needed, but the people we seem to have coming through needed stuff like two and three to one levels of care, you know, really, really complex cases and then you're unpicking all the issues around finances and property and affairs and we were saying "we need, are we doing that, the court of protection stuff now, the applications following capacity assessments and stuff?" And it was, like, no one ever gave us a straight answer."*

LA participant (integrated team)

The service provider aspect was less common but involved participants engaging with more 'hands-on' work with clients. Work in this context was often presented as longer-term and more involved, with participants undertaking a mix of monitoring and direct intervention, most usually around *"supporting them to kind of work out what their goals are…and then kind of supporting them to meet the goals that they want"* (Third sector participant). Service provision itself was often not clearly defined; outside of some specialist NHS services

with particular remits, participants spoke most often of frequent client contact and caseload management as generic concepts without clear purpose, with one local authority participant highlighting particular issues with this:

*"one particular client, he said, "I just want, I just need someone to come, come chat to me every two weeks, just like, just like [previous practitioner] did", but I'm like, "I can't come do that. For one thing, there's covid, and I'm not a chatting service". But that's what, that's what [previous practitioner] used to do. And so some people do become dependent on services. But [previous practitioner] was a care coordinator, you see, and he brought over - he was a social worker - but he brought over all his cases that was more social care rather than mental health over to us."*

LA participant (LA team)

Notably, in the context of service provision, NHS-employed participants were more likely to speak in terms of specific interventions, but where these occurred, the framing was of more medically or psychologically informed interventions: participants spoke about *"reviewing their mental state"* (NHS participant, NHS team), doing *"crisis management…around self harm and suicidal ideation"* (NHS participant, NHS team) and doing *"like a therapist role slash care coordinator"* (NHS participant, NHS team). While NHS participants did not speak exclusively in that type of terminology, they were more likely to do so than their local authority counterparts, who spoke less specifically about interventions, but more explicitly about a focus on social needs.

Indeed, although participants in all contexts undertook both gatekeeping and service provision roles, there were clear delineations between local authority responsibilities and NHS objectives. Local authority participants, regardless of setting, worked almost exclusively to fulfil statutory duties, with Care Act assessments and review and safeguarding investigations their most commonly mentioned tasks. Ongoing work involved a direct link to statutory duties, or, as one participant highlighted, by subverting the process to enable meeting needs that were not easily addressed through standardised approaches.

*"I've been working with a client who's got a hoarding disorder, probably since day dot really, not long after I started, so around eight months now. And he's got an assessment on the system and in… I'm not doing an assessment, I am doing an assessment in inverted commas, but within a statutory timescale, whatever that may be, 28 days. Well, I've not done an assessment within 28 days because eight months on I've still not wrote one. But, but that doesn't matter because I'm supporting him"*

LA participant (LA team)

By contrast, NHS participants, unless their roles were funded by local authority partners, framed their tasks in the context of achieving particular service outcomes, whether this was *"preventative work and just touching base"* (NHS participant, NHS team) as part of a broader service provision of care coordination, or meeting the needs of a particular identified group deemed of interest in that service context, For those participants working in specific, targeted services, as below, focus on particular groups of interest was framed through a service objective lens, with the emphasis on ensuring that the service recruited service users in line with its particular remit:

*"So, we'll look at the type of offenses that are coming in, see if there's anything unusual, particularly focused on women and people under 18 as well - we're trying to really kind of improve how, particularly for women, how they kind of come through the service"*

NHS participant (NHS team)

The final organisational role, the structural facilitator, was less focused on direct interaction with clients, but rather related to other roles and tasks participants undertook in the context of maintaining overall service provision, such as AMHP, BIA or duty rotas, or brokerage tasks. Participants distinguished these roles from their gatekeeping, facilitating or service provision tasks by emphasising the process of the task. Critically, it was not the work undertaken that fell under this categorisation, but rather the process of *"attending all relevant meetings"* (LA participant, integrated NHS team), *"doing social circumstances reports"* (NHS participant, NHS team) or having *"a duty rota that we take part in"* (LA participant, LA team).

These process-driven roles exclusively related to organisational needs, often either to meet statutory responsibilities for the local authority, or to provide service provision requirements for the NHS and occurred across all settings and working arrangements. This work was often framed as being an addition to the 'core' work of gatekeeping or service provision, with one participant suggesting *"it's like, it's like two jobs; you've got your job of when you're actually physically out there, practicing, doing your interventions and all those things and then you've got your second job."* (LA participant, integrated NHS team). Attitudes toward this type of work varied from acceptance to frustration; some participants accepted these manner of tasks as being *"just, you know, that's your role"* (NHS participant, NHS team), while for others the need to *""work out…[things]…on a council system that takes hours of my time where I could be talking to people"* (LA participant, integrated NHS team) echoed previously well publicised concerns across countries about social work perceptions of administrative burdens (YouGov, 2020; Samuel, 2020; NIASW, 2012).

### 8.3.2 The Statutory Agent

While statutory duties formed a core element of the organisational roles that participants were undertaking, as anticipated by Allen et al (2016), their accounts about their statutory role expanded beyond this. Participants laid claim to statutory duties in a way which went beyond an obligation toward their employers' responsibilities; legally defined tasks were situated as being 'our' responsibility or specifically denoted as needing a social worker, even where this was not specified within the underlying legislation. The Care Act (2014) duties upon local authorities were interpreted by the majority of participants in line with the legislative guidance (Department of Health and Social Care, 2022b) which assumes that local authority statutory responsibilities will be carried out by social workers. As one participant described it, in the context of concerns about competing NHS demands:

*"To me, statutory work is essential core work of any social worker. And sometimes it gets lost in the ether of the operational policies of the CMHTs."*

LA participant (co-located NHS team)

Only in circumstances where participants did not want to engage with statutory work – most commonly with safeguarding – did their accounts change to reflect that divorcing of the statutory duty from the social work practitioner. In contrast to the narrative of statutory work being the work of the individual social worker, participants who were reluctant to engage with this work framed it firmly as an obligation laid upon the local authority, which they were in turn expected to fulfil on the authority's behalf.

*"So obviously the local authority has a duty to investigate and enquire under Section 42 of the care act. And I get that. However, I don't always feel, I feel like we're often on a safeguarding machine."*

LA participant (LA team)

The narrative shift from *"assessing under the Care Act is **our** responsibility"* (emphasis added) (NHS participant, NHS team) to *"social workers who are funded by section 75 so have clear statutory requirements"* (NHS participant, NHS team) was a stark and recurring motif. In this instance, two participants, both employed within the NHS, positioned the requirement to do Care Act assessments very differently. For the first, these assessments were positioned as a core social work role regardless of context, where for the second, the same assessments are seen as a core local authority role, that should in turn only be undertaken by those social workers funded in post through an agreement with the local authority under s.75 of the Health Act (1999).

Legally defined roles such as the AMHP or BIA were often framed as *"an add-on to my role"* (LA participant, integrated NHS team), distinguishing them from the previously detailed organisational roles. Even for those minority of participants who were reluctant to adopt these additional roles, they were still framed in the context of being something additional to being a social worker in a mental health context, although in this context, they were viewed as something to be avoided. Critically here, participants distinguished between themselves as mental health social workers and themselves (or others) as AMHPs, unless their substantive role was in the AMHP service. The roles were seen as distinct from one another, with AMHP work being something that took time away from participants core mental health duties (Buckland, 2016).

However, the sense of being a statutory agent extended beyond the undertaking of particular statutory duties. This was especially true for NHS employed participants, whose roles often did not include direct responsibility for statutory duties beyond referral to the local authority. Those NHS-employed participants were often clear on the scope of statutory duties sitting outside of their substantive role, but still positioned themselves as supporting agents to the statutory role, in the context of offering professional commentary and collaborative input to enable statutory duties to be undertaken, as this participant describes:

*". But it's about us knowing what the obligations are in the, and of course safeguarding. I mean, you know, safeguarding. So I, again I'm not, you know, we aren't the, you know, we refer on to local authority in terms of safeguarding of course; we have to because it's local authority role, but we would kind of be the conduit and often the local authority'll come back to us for the safeguarding plans"*

NHS participant (NHS team)

Critical to this positioning was the sense of social worker not only as statutory enactor, but also as statutory expert. Participants incorporated into their statutory role the idea of expertise not only in the undertaking of statutory duties, but in the understanding of the provisions within the legislation relevant to mental health and how these were enacted in practice. Participants across all settings portrayed a sense of confidence in their statutory knowledge, which they used as a framework for practice, a resource to challenge practice with other professionals who they saw as less well informed and, as highlighted below, at the core of their professional distinctiveness within a multidisciplinary health team:

*"it's about using legislation isn't it, and that's sort of, like, that can be our sort of go-to, like, you know the CPNs have their medication, the OTs have their, like, OT assessments and plans they put in place, I don't think we have anything uniquely like that - ours, like, apart from using legislation and how that's interpreted"*

NHS participant (NHS team).

### 8.3.3 The Collaborative Agent

Working in partnership with other professionals formed a core element of the social work role across participant narratives. Despite the varied roles that participants undertook in a wide range of contexts, a central thread of working as part of a larger team of professionals to achieve the desired outcomes for clients was consistently articulated. This was viewed as a critical element of undertaking the tasks that participants needed to complete within their working contexts. The exact experience of this collaboration differed based on the team setting for participants; for those based in the local authorities, these collaborative relationships were primarily external to the team, with police and health agencies. Conversely, while those participants based in NHS teams did also maintain working relationships external to their teams - with care providers, commissioners and police - a more critical element of this team working for them related to effective inter-professional working within the confines of their own teams, undertaking tasks such as *"liaising with the psychiatrist"* (NHS participant, LA team), *"being asked to assess by a CPN" (*LA participant, integrated NHS team) or *"you make major decisions in a team meeting that you have weekly and you hold the risk together"* (NHS participant, NHS team). As the participant below highlights, internal collaborative working was at the backbone of the multidisciplinary working environment:

*"you need to work hand in hand during the crisis, you need to sort out a package of care on the social care side or residential care, whatever, while the nurse really tried to stabilise the mental side. So, you're working together"*

LA participant (co-located NHS team)

Across all contexts, however, participants spoke about collaboration as being something which went beyond merely team working. Participants spoke about engaging with other professionals and other agencies beyond the necessity to achieve particular outcomes; instead they focused on building relationships and generating contacts who were valued above and beyond their contribution to work with a particular client. Participants not only worked in teams, but they also built their own informal teams through *"respectful relationships with different people in different agencies"* (LA participant, LA team) by

engaging in ways that went beyond what was required. This *"more cultural stuff"* (Third sector participant) was seen as highly valuable. For the participant below, the ability to engage in meaningful dialogue with the co-located mental health team enabled them to work more effectively with their clients, even when those clients were unknown to the team members they were speaking with:

*"From your point of view, we know even if it's someone that they don't know about, you can have those discussions about what you're thinking and what you're looking to support that person with and realistically understand from the community mental health teams and the psychiatrist and the clinicians about what it is they'll be able to offer. Because often what ends up happening is we spend time doing referrals and we spend time doing, you know, sending emails out and thinking about that, but actually having that conversation means that you can aid your own learning a lot quicker."*

LA participants (co-located NHS team)

For integrated-NHS and NHS-employed participants in particular there was a symbiotic, reciprocal aspect to these relationships. Participants in these contexts viewed themselves as allies to their health colleagues, both within their teams and more widely within their organisations. This entailed 'stepping up' to ensure that work was being completed to the benefit of clients as a *"common courtesy"* (LA participant, integrated NHS team), but also more broadly making themselves available as a resource to support health colleagues, especially in the context of the pressures arising from the coronavirus pandemic. As one participant highlighted quite emphatically, the demanding contexts of colleagues' practice necessitated a supportive response:

*"And seeing what those nurses and, you know, were going through, especially when they were really short of staff, loads of people were off sick. They had, you know, about six patients who tested positive on the ward, you know, there was all, and have, like, I would really, I did, I said, "please tell me if I can help with anything, you know, we want to try and take as much pressure off you as possible." They are a bit understaffed."*

NHS participant (NHS team)

Local authority participants in local authority or co-located teams also spoke about working in similarly supportive ways, but, in their contexts, this support did not cross organisational barriers, reflecting one participant's view that *"psychologically, there's something about all working for the same organisation"* (Third sector participant). Local authority participants focused their reciprocal alliance on other social workers, and supporting care staff within their own teams, with the only exception to this being one participant whose organisational role specifically entailed working as a liaison across local authority, NHS and third sector services. This appeared to be less of an active choice than a lack of opportunity, however; with the barriers between separate and co-located services more fixed and less permeable than those for integrated or immersed social workers.

Indeed, setting boundaries was a more prevalent narrative of the collaborative role for local authority and co-located participants, than for their NHS-based counterparts. The more clearly delineated expectations of the services correlated to more clearly expressed boundaries to the social worker's role. While integrated and NHS-based participants spoke in similar role-limited terms about their interactions and collaborations with external agencies, within the context of health services those boundaries were sometimes less explicit, as these two conflicting accounts illustrate:

*"I think medication, medication wise I defer to our health colleagues for this. I don't know. I'm not an oracle on medication, I don't know that and I wouldn't profess to. I know of medication, that's not my specialism and nor should it be."*

LA participant (LA team)

*"as a care coordinator, I've done jobs that was previously seen as exclusively a nursing role, like, for example, giving people support and advice on medication issues, but having worked in mental health for 20 years, you tend to pick up stuff by osmosis about, uh, about it. So, I would say that I would know as much as some nurses in terms of medication in terms of the dosages, that rates, what would be considered side-effects, stuff like that."*

LA participant (integrated NHS team)

In the integrated context in particular, participant accounts on the extent of the social work (or, often, care coordinator) role showed wide variation. There was no consensus among participants on the extent to which social workers should undertake more health-based roles, as opposed to working collaboratively with health-based colleagues to ensure client needs were met. By contrast, LA participants and NHS participants respectively were often far clearer on the extent to which a particular undertaking fell under the remit and responsibility of the opposing agency. The critical challenge arose where participant roles straddled organisational boundaries, as one NHS participant in a dual local authority-NHS role described it:

*"I have to be very clear to other professionals, otherwise I'm constantly asked to be doing things that I shouldn't be doing that are either nursing related when it shouldn't be, or social work related when it shouldn't be. So it can be really difficult at times to strike that balance."*

NHS participant (NHS team)

Despite this specific challenge with boundary working, some participants offered a more outward-facing narrative, positioning themselves as crossroads agents similar to that identified in previous research (Tucker and Webber, 2021). In this context, collaborative work was something that happened both with external agencies offering different services, and with the formal and informal social networks surrounding clients. Social workers in this context sat at the interface between these differing systems, although not necessarily exclusively and positioned this work as critical in terms of *"mak*[ing] *social work relevant, and integral to health"* (NHS participant, NHS team) and proactively building cross-organisational networks. Although frequently linked to formal multiagency processes, such as multi-agency public protection arrangements (MAPPA) work, some participants also framed this in more informal, inclusive contexts that enabled them to work holistically with clients and their surrounding social networks:

*"And part of it is having those conversations with housing, with the provider, with his mum and dad, with anyone that's supporting that individual to go, "this is what I'm thinking and what do you see the risks as being?""*

LA participant (co-located team)

While not all participants spoke in these terms, those who did worked across all contexts and settings, with collaborative crossroad agent roles tying closely to participants' organisational roles.

## 8.4 Understanding mental health social work in context: the values-based role(s)

### 8.4.1 The Holistic Practitioner

Participants across all settings had a nuanced awareness of the need to view their clients in their broader circumstances and respond accordingly. There was a clear recognition that at the point of intervention, for the clients *"this is a certain point in their life, it's a certain context that we're finding them in"* (LA participant, co-located NHS team) and that that context needed to be considered in deciding how to approach effective intervention for that particular individual. Participant perspectives on this were broad; accounts acknowledged the immediate social circumstances of their clients, but also drew upon historical circumstances, life events and characteristics of the client, such as age or gender, that could influence their experiences. Participants did not view this contextualising of the client as an optional aspect of their approach; within the restrictions imposed by the coronavirus pandemic having a real and meaningful impact on participants' ability to engage with their clients in context, as one participant highlighted in the context of a *"very challenging"* (NHS participant, NHS team) year:

*"it's been the weirdest year ever…because we really wanted to be going and seeing everyone, seeing those environments that perhaps other people don't see"*

NHS participant (NHS team).

Critically, this contextualising view did not exclude the impact of the professional presence. Participants had a reflexive awareness of their own role and how practicing in ways that responded to context necessitated *"being very mindful that that doesn't blur into, kind of, something else"* (Third sector participant). In understanding the impact of broader context

for clients, participants were universally confident in speaking about their position within that context and their engagement with these narratives was nuanced and detailed, rooted in practical implications or, as with the account below, broader social work theory:

*"I think, you know, it, it's overriding especially even thinking like around human rights, you know, I'm working in a locked unit. I have a set of keys, physical keys that jangle when I walk, you know, you can't do that without understanding what that power means, particularly for, in a human rights framework"*

NHS participant (NHS team)

The holistic practitioner role went beyond this awareness, however. Participants incorporated this broader perspective of the individual into their everyday work both in terms of advocating for specific interventions and integrating this awareness of the client into how interventions were put into place. There was a clear sense of a necessity to view the whole person in context in order to work effectively with clients, with one participant arguing that *"if you don't consider the whole you're really going to struggle to move forward and make any changes."* (NHS participant, NHS team). Although some participants expressed a concern around the risk of overinvolvement, creating dependency and *"killing with kindness"* (LA participant, integrated NHS team), participants were able to clearly articulate examples of practice where their approach changed, or differed from organisational norms, in response to client specific circumstances and, again, this was often positioned as a necessity for effective social work practice rather than a luxury:

*"It also changes how I work with people in terms of, some people who don't have a lot of money and live in the middle of nowhere struggle to come to us. And my team, we have two teams and my team we normally expect people to come to us, because we see so many people, like, it would be a waste of time to go out, but actually sometimes we do have to go the extra mile because people can't come to you, for some reason."*

NHS participant (NHS team)

Adopting this perspective by necessity meant that participants practised with an outward facing focus. Advocating for client's holistic needs positioned the client in the context of

their wider circumstances, and focused on how particular interventions would interact with those broader circumstances to impact on the client. Correspondingly, participants considered their clients' experience as a whole, which frequently conflicted with the narrower focus of the services they were employed or based within. As one participant highlighted, this could cause difficulties within the proceduralised and financially focused structures of social work provision:

*"I put it through to panel and they said "this lady should be discharged from us. She's been, she's been under us too long, why are we going to fund that?" and it was like, "well, okay, but this is the drive you've been, we've been talking about personalised recovery. And actually, this is something that's really important to this person, and she might be stable, but actually, she's stable on her medication, there's many areas of her life that aren't stable, yeah, whatever that means.""*

NHS participant (NHS team)

In the holistic perspective, participants placed the client at the centre of their interventions, with an emphasis on *"looking at that person, their situation and then exploring with them how they feel services might best fit what's going on for them"* (LA participant, co-located NHS team) rather than having services dictate the nature of the intervention they were prepared to offer. There was a clear integration of social and mental health needs evident in participant narratives, alongside an acknowledgement that this was not necessarily a view shared across their colleagues in the health spectrum. Nonetheless, participant views across all contexts pointed toward an acceptance of mental health and social need as indistinguishable and interrelated, with social interventions as valuable, if not more so, than more conventional medical approaches and, as one participant explained, important to defend when working with clients in crisis:

*"I found that's been a lot more helpful: going out every day or phoning every day. Changing, you know, even if it's maybe getting them into emergency respite rather than getting them into hospital for respite. So I think my approaches are quite different in that term and I've also had many, many arguments with, with the consultants are just saying, "just get them into hospital", when I'm going, "no, no, we need to try the least restrictive*

*first". Yeah, so that always… I don't get, I'm not very popular when it comes to that. I think it's really important, though, isn't it? I think there's so many social things that you can change for someone that is impacting their life, that usually will bring them to a crisis point, and if you can reduce those things and make that less stressful then people aren't getting to the crisis point as quickly."*

NHS participant (LA team)

Overall, a holistic outlook that centred the client manifested in a range of different approaches to practice, usually related directly to the participant's particular workplace context and specific responsibilities. Participants advocated for the importance of *"being able to relate and empathise"* (LA participant, integrated NHS team), incorporating into practice *"those low level things [that] can make all the difference"* (LA participant, co-located team) or promoting more positive risk-taking approaches than health colleagues that supported clients in maintaining their social contexts, as one participant explained in the context of talking about Court of Protection work:

*"there's usually, health professionals usually – maybe, maybe I'm stereotyping and they do a fantastic job - but we are usually the ones kind of trying to fight to keep people at home, even in pretty risky situations. And I think that's, I wouldn't want that to disappear, really. I wouldn't want that to be swallowed up into… yeah."*

LA participant (co-located NHS team)

### 8.4.2 The Person-Centred Practitioner

Where the holistic practitioner was an outward facing role, that viewed the client in temporal, relational and social contexts, participants also adopted an inward-facing perspective which viewed clients as something more than a presenting mental health need. Participants spoke about clients in ways which were humanising, respectful and empowering, acknowledging them as autonomous adults with the power and capability to make their own decisions, while also *"trying to see people in terms of their vulnerabilities rather than diagnostics"* (NHS participant, NHS team), whose individual experience of mental health went beyond the management of symptoms, and which needed to be

responded to accordingly. As one participant highlighted, this did not always fit easily within the medically focused mental health environment:

*"I do think some of those conflicts about it, in meetings and conversations that I've been in about "oh, right, okay, medication, medication, medication, medication". And someone's going "I don't want to take medication, that means that I'm not sleeping as well at night. It means I'm drowsy during the day, it means that's why I'm not getting up to do my personal care. It means that, actually, I don't want to be on medication because if I'm on medication, I might be putting on weight and I don't want to put on weight because actually, I've already got this going on in my life." So, I think often thinking about alternative ways of people's support and people's recovery, we come in with that slightly different tactic, and that can be a real big challenge when you're in a meeting."*

LA participant (co-located NHS team)

Critical to the role of the person-centred practitioner again was that sense of the client being central to the process, and the need for social workers to work flexibly and creatively to achieve that centrality and to work in supportive ways. For some participants, this entailed pushing against the boundaries of service provision, to go 'above and beyond' their prescribed role in order to achieve the outcomes they hoped for with clients. As one participant succinctly put it: *"if a patient needs it, I think it's my job"* (LA participant, integrated NHS team).

This sense of boundary pushing also enabled participants to engage with what they viewed as the most important aspect of person-centred care: the building of effective relationships, mirroring the service user focus on the same found by Abendstern et al (2016). Participants acknowledged the usefulness of working with client needs rather than service expectations as a means of building rapport, but relationship building extended beyond that, to a consideration of *"how you communicate with them, how you engage with them, how you carry out your interventions"* (LA participant, integrated NHS team). That sense of engagement – building rapport, understanding experiences and developing relationships – was a fundamental cornerstone of how participants viewed social work with clients. In many ways, this mimicked the central tenets of the collaborative agent role; similar to when

working with other professionals, participants sought not only to work in partnership but to be a partnership, building relationships that were more tangible and lasting and *"getting to know the person and work **with** them"* (emphasis added) (LA participant, integrated NHS team). For those participants engaged in longer term support roles, this was easier to achieve; participants working in more time-limited ways were conscious of how briefer assessment roles limited the capacity for this:

*"So, I think I, what I really miss and what I'd love to be able to do more in this role is build that relationship on a sort of longer-term basis. That is very, you know, that's obviously something I could do as a care coordinator that I can't do now in this role, and that's the bit about social work I've always loved the best. It, like, it's the bit that I got into it for and why I stayed in care coordination for three years, that was just because I loved, I loved building that relationship with people."*

NHS participant (NHS team)

For one NHS-employed participant, effective relationship-based work did carry with it risks in the NHS setting linked to inappropriate case allocation, in particular for those difficult-to-engage clients with complex medical or psychological needs. Speaking in the context of a client presenting with complex psychological needs:

*"I did go to the lead and say, "look, I'm not sure if I'm the most suitable person to work with this person. Surely it would be better from someone from a psychotherapy background to work with them?". They basically said, "it's taken nine months for them to get your trust, so you're actually in the best position to support them now", and I then had weekly supervision for that case with the lead person to, kind of, guide me through it. And it was fine, but I felt way out of my depth"*

NHS participant (NHS team)

Collaboration was again clearly a central aspect of this participant's experience. Nonetheless, critically in this case, in line with the person-centred focus of this role, the participant's primary concern was not around their needs or the expectation that they

would take on work inappropriate for a social worker, but that, for the client, *"it was unfair on that person that they had me rather than someone else"* (NHS participant, NHS team).

### 8.4.3 The Challenge Agent

Participants in all settings saw challenge to the status quo, or to the dominant view, as central to their role as social workers. These challenges raised across all aspects of the professional relationships; from criticism of and resistance to societal level structural and policy-based concerns, through to challenges to clients who might seek 'easier' medication-based solutions to their difficulties, linking to their perspectives of clients as independent adults worthy of being treated as such. However, the most common areas of challenge lay at the organisational and individual professional levels.

Organisational level challenges were linked into the policies and practices of the organisations which participants were working within. In this context, there was a clear distinction between local authority and NHS settings; local authority participants spoke very minimally about organisational challenge. With the exception of one participant, who commented on challenging the local authority approach to supervision, local authority participants in local authority teams offered no criticism at an organisational level. By contrast, for some local authority participants within NHS teams (both integrated and co-located) there was a clear mismatch between their expectations as local authority social workers, and the expectations of commissioners, with one participant specifically drawing on the distinction between mental health and general adult social care as a means of understanding that:

*"I think, for as, I think, really, for as long as we, we might need to carry on with quite bespoke solutions, mental health is always going to feel like a slightly different thing to adult social care, and I think there would almost be more tension if we were, you know, in the kind of adult social care offices, going off script and kind of, kind of peeing off Commissioners to a certain degree"*

LA participant (co-located NHS team)

Organisational challenges in the NHS context, however, were clearly delineated by whether participants were local authority or NHS employed. For local authority participants, there was a clear need to challenge based on expectations that they would step beyond the bounds of their role, especially around the provision of health-related interventions. Participants saw it as their obligation to maintain appropriate professional boundaries, with one participant holding management responsibilities clearly articulating the need to maintain those boundaries as going beyond the individual social worker:

*"as a manager I've got very broad shoulders, and I do protect my social workers, I'll be fair, I do. I will say, "no, they're not doing that. No, they're not", and I do protect them as much as I possibly can from that, from them pressures"*

LA participant (co-located NHS team)

The need to challenges expectations that they would step outside of their role were accepted as a given by local authority participants in NHS settings, rather than something that needed to be justified. Nonetheless, participants clearly saw their refusal as justified, and their accounts saw rationales frequently offered:

*"I kind of turned those things down, I says "I'm not gonna do it, I haven't had the training and I don't feel comfortable in doing that."*

LA participant (integrated NHS team)

Participants within the NHS were equally willing to challenge their organisations; however, these challenges were framed more around professional recognition rather than boundary crossing. This was potentially a reflection of the nature of their roles, which were both defined by and undertaken within the NHS, as opposed to being defined externally by another organisation. Critical for NHS-employed participants was an acknowledgement that they were social workers, rather than a health adjunct. This manifested in challenges around job titles, protection and promotion of social work priorities and increased visibility of social work as something beyond a local authority role. NHS social workers were very aware of their positioning as non-health professionals within a health-dominated context

without a social work framework to support them, and this led to clashes between their professional expectations and their organisation's priorities, as one participant explained:

*"So, there was a real mismatch in what I was kind of, I guess, what's kind of embedded in social work and what I was there to do, or what I felt I was there to do, I suppose, compared to what the trust as a big organisation, thought I was there to do."*

NHS participant (NHS team)

For some participants, however, there was a cautionary aspect to adopting a challenging role with organisations, with an acknowledgement of the risk of *"being viewed as a troublemaker if you challenge the system too much"* (LA participant, co-located NHS team). One third sector participant offered an external perspective on this, noting the difficulties that NHS-based social workers could face because *"they have asked questions, almost as if that's kind of not done"* (Third sector participant). These participants sought to find a balance between challenging organisations where the need existed and finding ways to work around it where it did not. In turn, this enabled them to maintain working relationships they had worked to establish in other aspects of their role. For one participant, again, this involved an element of subverting the system to ensure that organisational aims did not preclude achieving the desired outcomes for clients, with a sense that *"sometimes we do actually end up having to kind of… not hide what we're doing in that we're doing anything, you know, dodgy with service users, but, you know"* (LA participant, co-located NHS team). The challenges in these instances became unspoken but implicit; participants rarely spoke about a willingness to surrender their principles, but rather a willingness to adapt their approach and be flexible in terms of how they achieved their objective to avoid, as this participant explains, creating future difficulties for themselves:

*"I quickly realised you have to build friends and, and you have to be, like, a political savvy operator, because you can't go burning all your bridges because you'll need people again. So, I've taken the viewpoint now that I kill people with kindness"*

LA participant (integrated NHS team)

Professional level challenges, by contrast, were an aspect of their role that united participants across all settings, and in turn were one of the elements which most distinguished them from their health-based colleagues. Professional challenges were aimed almost exclusively at health practitioners, both within and across teams and linked not only to client needs, but also to individual expectations of roles. This latter point was of particular contention for local authority participants in co-located NHS teams, who spoke insightfully about balancing the conflict of having a separate remit with the need to work effectively with their health colleagues. For one participant, being asked to undertake work on behalf of a consultant psychiatrist the fell outside the social work remit elicited this concern:

*"Our nurses in the team may do that. I always encourage the social workers to take a little step back: "That's not really your role". But it's easy to actually fall into it as, as a way of keeping the peace and just doing what everybody else does. So there are roles that social workers are asked to do where you do feel a bit uncomfortable at times"*

LA participant (co-located NHS team)

Nonetheless, at the individual level, participants demonstrated less of a willingness to compromise on their ideals and what they saw as their obligations both as a professional and toward their clients. Whereas at the organisational level, there was an acknowledgement of the need to preserve positive working relationships, with individuals, participants were more inflexible in their stance and prepared to *"wreck[s] relationships with health colleagues"* (LA participant, integrated NHS team). In this aspect, participants appeared to view the challenging nature of the social worker as integral to the role they played within mental health services, and this in turn made it a fundamental principle of practice. Compromise, from that position, represented a loss of the social work stance, with the corresponding risk of social work priorities being overridden by other agendas, as illustrated by one participant who positioned challenging unfair procedures in place in a hospital setting during the height of the coronavirus pandemic as a clear priority over maintaining relationships with hospital staff:

*"It's just like, "how dare you question us, because all we want to do is care and love people, or make people better", but those sort of intricacies they miss. And that's why you have to have a social worker, and if you have a nurse, they wouldn't be thinking like that. So, you know, we kicked up a big stink about it, not that anything's been done, but you know, the fact that we do, we fight because that is our role, but they still think we're being difficult, but I don't get it, I don't understand why they don't get it and they don't understand why I don't get it. But you do need that difference."*

LA participant (LA team)

NHS-employed participants had a particularly nuanced awareness of the power differential between social work and health staff, with some commenting on the dominance of the medical perspective and highlighting "*that was a very, very, very strong voice within the team, and I think as social workers we, we had to shout quite loud."* (NHS participant, NHS team). This narrative of medical dominance was less prevalent from local authority social workers, who acknowledged the differences in approach but who seemingly felt more confident to challenge, especially within the context of their statutory frameworks for practice which gave a default position of *"well, sorry, it's written in law"* (LA participant, co-located NHS team). For the NHS-employed social workers, again, there was a sense of the absence of that framework influencing not their desire or willingness to challenge, but their approach to doing so, to fit within the context of their health-defined roles and adapted to *"the culture of the team"* (NHS participant, NHS team).

### 8.4.4 The Social Justice Advocate

A less commonly expressed adjunct to the challenge agent, the social justice advocate was nonetheless a recurring theme across a number of participant accounts in all contexts. In this narrative, injustice arising from either an individual's circumstances, the nature of service provision or the wider social context were openly acknowledged and challenged by participants, sometimes quite passionately:

*"You know, we're trying to build a fairer society and we've been trying, social workers have been trying to build a fairer society, since, well, goodness knows, 1800s, basically. And*

*it just hasn't, it's still not happening. The poor will still be shit on by everyone else, and we still get a perception of goody two shoes and do-gooders and all this sort of crap and lefty, lefty socialists and it's like, ah, come on!"*

LA participant (LA team)

Where this position differed from the challenge agent was in the acknowledgement of the likelihood for change. While participants were keen to stress the importance of advocating for clients against what they perceived as individual, structural and societal injustice, there was also an awareness that, with these issues, change was unlikely and unexpected. Participants did not advocate for clients in this context because they expected their advocacy to succeed; instead they saw this as a responsibility to at least try, as an implicit expectation of maintaining their social work stance against the 'norms' of the system. Social work was positioned as *"promoting independence, autonomy, rights based practice"* (Third sector participant) with an expectation that it would see *"at the very least, attention directed toward the concept of wider social vulnerabilities"* (NHS participant, NHS team). As one participant highlighted, in terms of changing embedded structural inequalities, awareness raising was an expected practice minimum even if change was unlikely:

*"I can sleep at night because I raised it, and they can choose to do nothing about it"*

LA participant (LA team)

Participants were realistic about their ability to make changes to underlying injustices at a systemic and societal level. They were aware that service shortfalls and legislative and policy-based injustices were beyond their capacity to change as individual practitioners, although this did not preclude *"the passion I've got in me about bringing change to people's lives"* (NHS participant, NHS team) about it. Although some participants expressed frustration about this inability to achieve change, as social justice advocates, there was also an acknowledgement about the longer-term nature of challenges to inequality, that in order to achieve larger structural changes, smaller localised differences needed to be achieved, and that cemented a willingness to continue with what participants frequently framed as an ongoing struggle. For one participant, attempting to challenge dominant medical models started with small steps:

*"I actually gave it* [social work policy] *to him. I wouldn't hold my breath that he read it but absolutely. I think it's an essential one, it's really, really helpful. And it just really helped me also to feel better about standing up for social work, standing up advocating for the client, advocating for our values. I'm a big believer, huge believer in a social model of disability. And that plays a big role in what we're doing, which is a constant fight basically fighting against medical model, especially when you think about personality disorders and that kind of stuff. So yeah, it's a constant topic."*

LA participant (co-located NHS team).

## 8.5 Understanding mental health social work in context: the knowledge-based role(s)

### 8.5.1 The Knowledge Specialist

Participants positioned their specialist knowledge in the context of two key elements: a subject specialism in mental health and, reflecting the existing literature, a systems specialism in social systems and in social work legislation, policy and processes (Abendstern et al, 2016). Participants saw their mental health subject specialism as a critical aspect of being a mental health social worker; while not all participants saw having prior mental health experience as a requirement to enter the role, they did all agree that sustaining the role without developing that knowledge rapidly was an untenable prospect:

*"I'd say it is critical, I'd say understanding of mental health disorders is… you do really need it. You really do need it. And it was a caveat of me starting the training that that was one of my learning objectives, that before you start the training we need, we need to get that ground level knowledge. But that can be learnt."*

LA participant (LA team)

By contrast, holding specialist social work knowledge was a role more imposed by external parties. While participants did not dispute their knowledge of social work structures, they framed this knowledge specialism as something expected of them, rather than something

they claimed for themselves, and the extent to which this was critical to their role depended heavily on the exact nature of the job they had been employed to do.

*"we do the same – apart from depots, obviously - we do the same job. I mean, and I say that, but I think what always tends to happen is when a complex case comes up, particularly if it's around funding, I think there's a tendency to give that to a social worker."*

LA participant (integrated NHS team)

The extension of this same expectation to knowledge of social structures, particularly around issues such as housing and benefits, elicited a more mixed response. For some participants, that knowledge of how social structures work was integral to social work training and a holistic approach to working with clients; for others, it represented a specialism outside of their social work focus, and they spoke in resisting terms about the expectation that *"we seem to be housing experts now"* (NHS participant, NHS team). Nonetheless, the interplay of specialist mental health knowledge and specialist social work knowledge, positioning participants as having expertise across multiple dimensions, was acknowledged not as a weakness (Webber, 2013) but as a particular strength of mental health social work.

*"I think if you, if you didn't come from that background within social work, I think that would be a real struggle. And I think if you're a CPN, for example, coming straight from a ward where largely, your job is going to revolve around medication and obs and, and all those kind of things, I think the social aspect would be pretty challenging, in terms of maybe knowing, knowing what questions to ask, I suppose."*

NHS participant (NHS team)

Knowledge specialisms were not presented as equating to knowledge dominance. Participants were aware of the strengths and shortfalls within their own knowledge bases and, particularly in relation to mental health medical knowledge, saw it as *"very important to be mindful of your limitations"* (Third sector participant). They were able to take ownership of their own knowledge limitations without viewing these as any form of deficit or failing. Indeed, the converse generally held true. Participants keenly identified

circumstances where additional training would support their knowledge development and the concept of experiential knowledge, learning developed in context and 'on the job', and *"learned a great amount about mental health from that environment"* (NHS participant, NHS team) was something that they openly acknowledged (Tucker and Webber, 2021; Webber, 2013). This was predominantly presented in positive, beneficial lights, although for those working in multidisciplinary contexts, there was a note of caution that entering a mental health role without a base level of experience led to the risk that *"you would be run rings around by the other, potentially by some of the other staff in the multidisciplinary team"* (NHS participant, NHS team).

While knowledge specialism was a recurring element of the social work role for all participants, regardless of context, there were differences in how this impacted on undertaking their work. Where this role differed was not in terms of the participants' positioning, but in the positioning of those they were providing the knowledge specialism for. In the context of work with clients, participants spoke about the expectation that they would draw upon all aspects of their knowledge base and felt that they were expected to demonstrate a good level of knowledge across the spectrum of mental health, social work and social structures, again acknowledging that *"a social worker's role is to not necessarily know everything but know where to go to get the answers"* (LA participant, LA team). However, the situation with other professionals was more complex. For local authority participants, workplace context was key; those in local authority settings, surrounded by social work colleagues, were not generally seen as social work specialists, but as mental health specialists and their primary unique contribution in that setting related to their mental health expertise.

*"So, we are the kind of go-to team for information around mental health; there's no ifs, buts or maybes that's because we're the mental health team. It's what we do"*

LA participant (LA team)

By contrast, local authority social workers in NHS settings, unless liaising across organisations with social work colleagues, were social work specialists rather than mental health specialists. Understanding of legislative expectations and social care policies,

especially related to capacity, care funding and safeguarding, formed the basis of their professional expertise in this context. With the exception of the specific AMHP role, which again related to an understanding of the mental health legislation rather than mental health as a broader topic, participants in health settings were positioned as social care experts by their health colleagues, who looked to them guidance on the legal frameworks relevant to practice:

*"I think when we look at like safeguardings, the processes and what things we need to be looking out for, I think they do look at the social workers to have, kind of, answers or guidance in that respect. We're experts of that."*

LA participant (integrated NHS team)

In the context of each organisational setting therefore, participants, crossing the boundary between social work and mental health, filled whichever knowledge gap applied for the context they were working within. This was replicated in the experience of NHS-employed participants. These participants positioned their mental health knowledge as critical from their own perspective, linking this to their ability to maintain their position within the health-dominated multidisciplinary team. They saw their understanding of the relationship between social factors and mental health as their significant contribution to the multidisciplinary team, especially for teams previously lacking social work input *"because, you know, often, lots of people turning up would have lots of social components to their presentation and their mental, mental distress was not always biologically driven"* (NHS participant, NHS team). However, in terms of the expectations from their health colleagues, it was their social care knowledge that dominated the professional interactions. This was not to say that participants felt their mental health knowledge was viewed as subpar by their health colleagues, but instead reflected the expectation that the mental health social worker would fulfil the 'gap' within the broader workforce knowledge base and that health definitions of that gap potentially differed from participant definitions. As one participant recounted, on their specialist contribution to an otherwise health-staffed team:

*"I might, the only thing I've noticed so far is that they all come to me about safeguarding, which I expected as soon as I heard I was the only social worker. I thought, "okay, that's going to be…""*

NHS participant (NHS team)

The externally imposed role of 'knower of social work', while not always in line with participant priorities around their knowledge base, was nonetheless one which they fully recognised and anticipated in NHS contexts.

### 8.5.2 The Educator

For a smaller subset of participants, social work education also formed a critical part of their role. Very few participants had formal educator responsibilities built into their substantive role; only one local authority participant and one NHS participant, both employed in a support capacity, described delivery of training as part of their substantive role. However, several participants based in NHS contexts prioritised opportunities to deliver informal training to colleagues across agency spectrums and professional specialities. This informal training took a range of forms, but generally occurred in an unstructured and ad hoc manner, as an addition to their usual duties. The focus, however, was almost exclusively on developing understanding of the social work role and contribution to mental health contexts. While two participants did highlight promoting knowledge specific to mental health contexts, the critical element of their focus was on that context, breaking down conceptions to more person-centred and holistic understandings of the social work contribution to the client experience.

*"I think that, my goal is, as far as I would hope, and I don't know, you know, is that if people were to ask, if I was to ask those questions again, not necessarily me but a new social worker coming in, because, if you were to ask people, those questions again - what does social work do - I hope the answers would be a lot clearer now through my work over the past year."*

NHS participant (NHS team).

This prioritising of the social work perspective specifically in the context of medical and health dominated settings may explain why this narrative was absent from the local authority participants based in local authority contexts, where the social work perspective already existed as the dominant idea.

Interestingly, informal education also formed part of the narrative for both third sector participants, who described prioritising opportunities to share knowledge internally with both social work and mental health colleagues to support a more socially informed approach to mental health intervention. In both participant narratives, undertaking this knowledge sharing this exercise was a self-led activity, instigated by participants in response to an identified opportunity, and represented a proactive approach to share practice relevant knowledge that would ultimately improve the client experience of the service.

### 8.5.3 The Discourse Challenger

Perhaps underpinning the drive to educate colleagues, participants based in health settings also positioned offering social and rights-based models to challenge the medical hegemony as central to their role. Participants saw the social model in these contexts as a challenge; they positioned social perspectives not as a contradiction to medical perspectives, or as a subservient idea, but as equally important and of equal importance in understanding the client experience of mental health. In this sense, the discourse of the social perspective was positioned as a challenge.

*"To me the care coordinators role should be again multifaceted and more in terms of the social, the social-economic, and health sort of sides of someone's illness, looking at the bigger picture. That's not to say that some workers can't think outside, some workers are very, very difficult. If you're very health, health driven and you're only used to maybe giving someone a depot, really, really difficult structurally and culturally to break that barrier down, to say to one of your health colleagues, "well, sorry, but you've got a responsibility to the social role as well as the medical role and it's all of our roles to do care coordination"."*

LA participant (co-located NHS team)

Participants framed these challenges to medical dominance as often resisted and frequently *"only brought up by me"* (Third sector participant), although for some participants there was a hope that *"other professions are becoming more social focused and more, gaining more of a social perspective"* (LA participant, integrated NHS team). Similarly, there was caution against assuming that *"the police or nurses or OTs or anyone else don't, don't have a values base"* (Third sector participant). Nonetheless, there was a recurring narrative of *"an essential difference in orientation that comes from the professional training"* (NHS participant, NHS team) and if the social perspective was not built intrinsically into the design of a service, with health-based colleagues already experienced in working in a socially-minded way, participants equated the introduction of the social perspective into NHS-led mental health services as an *"ongoing battle"* (LA participant, integrated NHS team), albeit one they were determined to fight.

This determination was rooted within the inherent value of social models, as participants perceived them. One participant cautioned against an overreliance on the social model to the exclusion of the medical model, but this was rooted in adopting an understanding of the client experience in a way which corresponded with their lived experience, rejecting Goemans (2012) position that excluding the medical model was essential to a genuinely social perspective. Indeed, a more diluted version of this narrative formed the main 'criticism' of the social perspective, positioned around the need for a social model to exist alongside other models, acknowledging that *"if you just got rid of everyone and just had social workers in mental health teams, that's not the answer"* (Third sector participant). Beyond this, however, participants spoke extensively about the benefits of social models through the lens of contextualising clients within their wider experiences, understanding the complex construction and interplay of factors within their lives, that would in turn improve understandings of and responses to their experiences, and facilitating a move away from individualistic blame narratives of mental health, to more inclusive, socially situated understandings; as one participant put it, a move from *""what's wrong with you?" to "what has happened to you?""* (LA participant, co-located NHS team).

While adoption of social models was a key objective for participants in this aspect of their role, a potential source of frustration for a few participants was the experience of social

models being incorporated into wider service design without a consideration of how these models needed to impact on actual service delivery. Participants, who had demonstrated clear understandings of the social model in practice, were quick to identify where these social approaches were adopted in a tokenistic rather than a meaningful way and were equally quick to take action to challenge their organisations. Acknowledgement of social models was not seen as sufficient, unless this was supported by real change in how service models were constructed and delivered.

*"I think one of my, one of my biggest bugbears at CMHT was that everybody was shouting about personal budgets, everybody was shouting about personalized recovery, person-centred care, it was a huge thing that the NHS were driven, you know, there was obviously a real drive to focus on and stuff. But, actually, it was really difficult to play out"*

NHS participant (NHS team)

This inability to enact socially driven interventions encapsulated the real challenge of presenting the alternative discourse. The social perspective in participant accounts was easier to evidence than to define; participants were able to discuss how social perspectives complemented or challenged medical narratives, but this was couched in general terms of *"the link to the community and to family and to volunteering, work, education, that kind of thing"* (Third sector participant) or in specific examples from practice often linked to diversion from hospital. The broad scope of the social perspective arguably required this lack of specificity in order to be inclusive, but, for one participant, this neatly captured the challenge in getting the model accepted in more rigid, medically dominated structures:

*"I think sometimes like for ourselves and other professions it's hard to see what our uniqueness is in a black and white way; it's really grey. And I think that's because it's black and white medically, you know, the medical model is black and white, OT is black and white, what we do is grey and we're trying to dress it up in a black and white way."*

NHS participant (NHS team)

## 8.6 Conclusions

Participants' experiences of their role can ultimately therefore be framed around three core principles that in broadest terms transcended employment and workplace contexts. Definitions of self were linked to 'what we do' (task-based roles), 'how we do it' (value-based roles) and 'what we know' (knowledge-based roles). However, in order to capture the full diversity of mental health social work practice, these frameworks were by necessity broad and generalised in scope. Roles were not constructed around specific tasks, values or knowledge that participants were expected to undertake or bring to their daily work, but rather around conceptual typologies that were adaptable to variations in practice contexts and participant experiences.

Nonetheless, variation within the roles was evident in the accounts. Variation in task-based roles was closely linked to employment context, with NHS-employed participants more likely to be engaged in service provision roles and less likely to work centrally in statutory roles than their local authority counterparts. Similarly, it was the NHS context that dictated differences in how participants engaged collaboratively with colleagues; local authority participants saw collaboration as primarily an external activity, where for integrated and NHS participants, collaboration started first and foremost in the context of their own teams.

By contrast, participants' experience of value-based roles largely correlated across all contexts, with one notable exception. As challenge agents, the experience of local authority and NHS participants differed significantly in the area of organisational challenge. With the NHS as the primary setting for this manner of challenge, local authority participants were keenly aware of their boundaries and the importance of maintaining these, while for NHS participants establishing their position as social workers rather than 'honorary' health staff (Tucker and Webber, 2021) was critical. In these contexts, issues of power intrinsic to challenging an employing agency versus challenging an operational partner also manifested clearly in participant accounts.

Knowledge-based roles saw participants positioned as a multifaceted expert in both mental health and social structures, with the prominence and perceived benefit of each element of this knowledge base highly dependent on the practice context. Expertise was linked to uniqueness, with mental health knowledge seen as unique in local authority contexts and

social structures in health contexts. Acceptance of participant expertise was not a given, however; clear from participant accounts was a willingness with NHS settings to prioritise knowledge around the specific processes and remit of local authority social work, but substantially less universal willingness to engage with social models as an alternative to the dominant medical discourse. It was in NHS settings almost exclusively therefore that the discourse challenger role took prominence.

Definitions of role do not comprehensively capture the variation that context brings to mental health social work practice however. Participant accounts were not restricted to the roles they undertook, but rather influenced by a range of broader environmental factors that influenced their conceptualisation of self and of the contribution they made to mental health contexts, and it is an exploration of these broader factors that this analysis will now explore.

# Chapter 9 - Results: The contextual factors influencing mental health social work

As might perhaps be expected for a profession rooted in the realities of its practice setting, broader contextual factors impacted significantly on participants' approach to how they undertook their roles and, more broadly, on how they experienced mental health social work. The second aspect of the qualitative analysis therefore focused on this, with the aim of addressing the wider aspects of the second primary research question exploring how employment circumstances and context impact on participants' understanding of their role. This chapter explores the influence of these factors within a framework of relational, locational and structural factors, in terms of their overall influence, and the extent to which these varied between different practice groups.

## 9.1 Overview of the findings

Although not independent of the roles, the wider contextual factors identified were those which existed beyond participants' work and usually influenced across multiple roles. Again, these fell broadly into three categories, albeit with substantial crossover between the three which reflected the complex and multi-faceted nature of the contexts within which participants practiced. These three categories were defined as: relational, locational and structural, with each category representing two or three key factors as follows:

**Relational factors**

- Clients in context
- Interprofessional relationships

**Locational factors**

- Organisational influence
- Physicality

**Structural factors**

- Formal frameworks
- Professional skills and knowledge
- Support and development

Relational factors linked to social work roles as holistic, person-centred and collaborative practitioners in acknowledging and actively exploring the impact that those people with whom social workers interact exert over social work practice. Locational factors similarly highlighted the significance of social work positioning within mental health, not only physically but also conceptually, taking location beyond purely physical presence. Structural factors reflected the influence of wider structures in the extent to which they informed, guided and supported mental health social work practice.

## 9.2 Understanding mental health social work in context: relational factors influencing experience of the social work role

### 9.2.1 Clients in context

Participants across all settings had a nuanced understanding of how their client's contexts on the micro, meso and macro level impacted on their working relationships. The same awareness that they brought to their roles as holistic practitioners in turn manifested in an understanding and recognition of how individual, cultural and wider societal influences affected how the clients engaged with them and, in turn, how they could effectively engage with their clients. At an individual level, participants were acutely aware of the importance of their clients' individual characteristics in terms of influencing their working relationship in both beneficial and detrimental ways and, in turn, how the characteristics they themselves brought to the table could compound or mitigate this issue.

*"we modify our approaches to whoever we're dealing with. Some individuals, you know, I'll speak, well, like I'm speaking to you with a bit more highbrow, a bit more language based. Other individuals you adapt and you, you change your behaviour with; you'll be a bit more colloquial, you'll be a bit more laddish or whatever, you know. Just to kind of build up this, this, this kind of relationship."*

LA participant (LA team)

Characteristics in this context were not limited to physical or locational influences. There was also an acknowledgement among participants of the particular challenges facing clients struggling with mental health issues, who were likely to experience particular difficulties that directly influenced the working relationship with their social workers. Participants openly acknowledged the risks of stereotyping in these contexts, but without disregarding the significance of the experiences that inform those stereotypes.

*"it's just, especially in adult mental health when, you know, when you've got, I don't want to go into the stereotype too much, but we do have a number of people with personality disorders who for their own reasons - trauma history and stuff, so I'm not judging - but there is a lot of reoccurring issues."*

LA participant (co-located NHS team)

Clients were also recognised as being culturally situated, in the context of their immediate communities and social environments, with these settings playing a substantial role in where participants chose to focus their assessment and intervention approaches. While the broader substantive roles remained similar across contexts, participants demonstrated an awareness that *"people have connections and links with where they're from and, you know, it's really important to understand them"* (NHS participant, NHS team). This understanding of the cultural context of clients was both historical and contemporary; while views were divided on whether local knowledge was necessary in order to be able to work in any given geographic context, participants held widespread agreement that the respective community contexts in which they worked held significance for their clients and, in turn, were relevant in considering how to practice with them. For one participant, who had relocated from a small, wealthy, rural town to a deprived, inner-city area, the contrast was particularly stark:

*"I wanted to work in a place where I was actually going to come across completely different issues than I've come across before. So, I mean, yeah, now on a day to day basis, I'm seeing people who have stabbed people, who are supplying Class A drugs - the list, the grim list, goes on and on and on, but it's, it means that I'm asking completely different questions, like I said, so I'm, I'm having to - and this is a change I'm kind of still making, definitely – what, when I'm, when I'm seeing an 18 year old, for example, working in [other*

*area] I might have been saying to them, "are you thinking about going to university? Are you, you know, what kind of career are you thinking about?". It was, that was tended to be the conversations you were having. Whereas now if I'm seeing an 18 year old…and I'm saying "what are your friendships like? Who you're hanging out with, you know, are you drinking alcohol? Are you taking drugs? How would you like your life to be different?" rather than focusing so much on, kind of, I don't know how to put it really, but things like university and, you know, goals which are quite privileged, I suppose."*

NHS participant (NHS team)

Participants also positioned clients in a wider societal setting, again with an awareness of how structural norms and expectations influenced both client expectations and service realities. In turn participants acknowledged a need to manage these as part of executing their roles, especially where they led to conflicts between "*an expectation culture"* (LA participant, LA team) and a practice environment dominated by service reductions which participants in part attributed to right wing, neoliberal political influences and the ongoing impact of the austerity agenda. For some participants, there was an acute awareness of practicing both under an umbrella of blame and accountability and in the context of *"the individualisation approach"* (NHS participant, NHS team), which both limited the extent to which meaningful interventions, as they defined them, were available and to which they could draw on external structural resources in a productive way. Indeed, as one participant highlighted, the wider structures of the welfare state could not be assumed to be a resource as opposed to a barrier when undertaking work with clients:

*"The shit that we've had to deal with because people have been sanctioned for no reason, or had their benefits changed, or have had something altered for nothing that they've done, no fault of their own. Or have been told to attend an assessment suite, and then have been lied to at the assessment and that's happened to me; I supported one of my clients to an assessment. And when the report came, it said "you attended on your own". It's not even a good lie."*

LA participant (LA team)

Perhaps unsurprisingly, participant narratives around clients in context linked closely their positioning as holistic and person-centred practitioners. Practitioners demonstrated a nuanced and detailed understanding of the circumstances surrounding their clients from an ecological perspective, positioning the client in their environment on a micro, meso and macro level (Teater, 2014) and how these factors interrelated and subsequently informed their own practice in terms of anticipating personal barriers on the micro level, meeting cultural expectations on the meso level, and responding to hidden threats embedded into clients social contexts on the macro level. As one participant suggested, practicing in holistic and person-centred manner necessitated *"having that background understanding to work with someone"* (NHS participant, NHS team).

### 9.2.2 Interprofessional relationships

Policy and academic narratives around the criticality of multidisciplinary and interagency working in providing effective care did not translate smoothly into the participants' practice realities, reflecting Brown et al's (2000) expectation of professional difference operating as a barrier to effective multidisciplinary working. Participants described an environment of professional expectations which swung across extremes; at one end of the spectrum, participants spoke about a continual push back against the expectation that they would just 'do' social care interventions, as defined by other practitioners who they saw as having no clear understanding of what social care interventions comprised. For some participants, this mentality fed clearly into client expectations for services that participants could not always meet:

*"So, the wards and the hospitals say "oh, why don't you place them there?" So, and then you really have to argue based on the law, this is, they actually don't have eligible needs."*

LA participant (co-located NHS team).

Conversely, the opposing expectation was of a health dominated service provision, which prioritised the needs of the NHS services to the exclusion of the social care responsibility. Participants therefore identified a similar struggle, but in this instance the focus was more

on retaining a social work identity and avoiding being subsumed into a health-driven hierarchy, overseen by medical priorities as defined by consultants. For those participants based within NHS contexts, especially those with obligations to local authorities, this posed a particular challenge. Mental health social work in this circumstance was seen as unrecognised and unacknowledged, with a corresponding unrealistic expectation of the work participants would therefore undertake:

*"We do a lot of things within the CMHT that actually goes unrecognised with our Health Partners; statutory work is a huge drain on our resources, yet sometimes we're expected to carry the same caseloads so there's, there is a lot of conflict that can actually occur in terms of our, our ability to support the operational side of the CMHT and trying to find a happy balance of our roles as social workers within, within the bigger picture."*

LA participant (co-located NHS team)

This latter experience was echoed by some participants working in forensic contexts, although in this context, medical mental health needs came into conflict with policing expectations. In all examples, however, participants positioned themselves, however unwillingly, in the more disadvantaged and less powerful role, working as a direct challenge to them effectively fulfilling their role as a collaborative agent.

Positioning on this spectrum was also influenced by the participant's employment structure. While there was some variation linked to the exact specifics of each service provision, as a general rule, it was those participants working in more separated roles, usually within LA and co-located NHS teams, who worked with misleading expectations of their role or situations where *"they're not really clear about what social care is meant to do or what a social care intervention would actually achieve for someone"* (LA participant, co-located NHS team). For them, professionals across other services, including general adult social care, could struggle with understanding the form that specialist mental health social work took. However, increasing degrees of integration did not necessarily address this misunderstanding. Instead, participants were more likely to speak of an escalated invisibility, with the sense that *"people do overlook that I am a qualified social worker and*

*they just assume I am a trained nurse"* (NHS participant, NHS team), especially for those integrated participants who did not hold defined statutory responsibilities.

Although participants viewed collaboration as one of their critical roles, they classified their interprofessional relationships as being built on one of three foundations: misunderstanding, conflict or co-operation, with misunderstanding the most prevalent. Regardless of each participant's employment context, setting or substantive organisational role, a lack of understanding of their position within mental health services formed a substantial part of their narrative around interprofessional relationships. Both internally and externally to teams, participants recounted misunderstandings about tasks which fell under their responsibility, statutory duties which were not specifically linked to social work, the appropriateness of referrals and, particularly for those participants engaged in arranging care plans, a lack of understanding of the social care role in meeting mental health need.

*"It's kind of like, well, psychology does this, you know, it's very clear what psychology does, it's very clear what OT does, it's very clear what the nursing staff do, it's very clear what the doctors do. Who knows what social work does, you know?"*

NHS participant (NHS team)

Employment status and setting appeared to have minimal impact on the frequency with which participants encountered misunderstandings of their role. In some instances, in the absence of a clearly defined and consistent social work role in mental health, frameworks for understanding appeared constructed within the other professionals' specific sphere of influence, with health colleagues placing a greater emphasis on mental health need, while social work colleagues prioritised statutory duties generally associated with social work. Those professionals' corresponding expectations of what the social work role in mental health *should* be did not always match with the participants' understanding of their own position, and necessitated participants offering a defence of their intervention recommendations which were rooted in fundamental conceptions of mental health rather than the needs of the specific client:

*"you're having to have quite interesting conversations, even within adult social care, about why the mental health manifests itself in this way, which means that this person may be low in mood, mornings might be more difficult, so when their partner isn't at home, that's when they need more of the emotional support, and why you're being more creative with looking at that person's wellbeing, that might not be "need a shower once a day, need their three meals cooked and half an hour is long enough" that actually is slightly different, you know, in the way we work."*

LA participant (co-located NHS team)

Conversely and more commonly, in other cases, participants saw professionals as positioning their role as 'other'; with responsibility passed to social work for any aspects of mental health care which fell outside of the professional's own identified responsibilities, without consideration for why these aspects of care and support should or would fall under the remit of social work. This misunderstanding lay at the root of participants' frustrations with inappropriate referrals, with some participants experiencing strong emotional responses to what they saw as continual and sustained ignorance from other professionals.

*"I feel some of the nursing staff are stupid in terms of they'll just, they put absolutely horrific referrals through via social care for us. For instance, I had a safeguarding because a pie was thrown out of the communal fridge in a supported living. What, what, what am I, in my role as a social worker, supposed to do with that, do you know what I mean? I feel that the ignorance is getting worse."*

LA participant (integrated NHS team)

Participants saw challenge as integral to addressing misunderstandings of their role, and there was very little willingness to accept outside interpretations of either how they should or did undertake their duties. How this challenge manifested, however, was heavily informed by participant employment context. For NHS-employed participants, challenges to misunderstanding were most likely to take the form of education, with ongoing attempts to *"persuade people or…remind them all the time what my job was meant to be"* (NHS participant, NHS team). Conversely, for local authority employed participants, boundaries formed an integral element of how participants managed their interprofessional

relationships. While external practitioners might demonstrate a lack of clarity and understanding, participants were clear on where the limitations of their interventions lay and on their own responsibility to ensure these were respected, most frequently enacted through adherence to their own referral and assessment processes with a reliance that these assessments will demonstrate where *"the situation isn't as, as risky or as of need of our specific service around the mental health as it might have been seen to be"* (LA participant, co-located team).

For some participants, this maintenance of professional boundaries, whether personal or organisational was a source of inter-professional conflict, in particular where health and local authority priorities contradicted or clashed. This could be a quite specific and focused complaint, often linked to service structures or reorganisation, as one local authority participant noted.

*"they are still complaining about us, years ago, having pulled out and not doing care coordination anymore and having pulled out of duty and all this kind of stuff"*

LA participant (co-located NHS team)

However, conflict also manifested representing a broader disconnect between social care and health priorities and differing professional importance attached to those respective objectives. For some participants, this linked to an escalation of the misunderstandings around the scope of their role; in other instances, it reflected a more instinctive response to the challenge aspect that participants saw as integral to their role. Participants understood the link between challenge and increasing confrontational response, but narratives suggesting that challenge should be avoided for that reason were minimal, as one local authority participant described in relation to clients right in hospital settings during the coronavirus restrictions:

*"It's funny, it's a funny one, because it sounds challenging, and I think that we normally have a really good relationship with them, but it's this covid that's caused all the problems, because we've challenged them for putting mental health patients in covid areas,*

*so they really now are, that's really… instead of being able to work together, that's really, I think, they've sort of felt quite threatened really."*

LA participant (LA team)

This manner of conflict defence was not unique to other professionals, with participants acknowledging both potential threats linked to their practice and the need to defend against these. While challenge leading to conflict was often rooted within a person-centred, rights-focused perspective, participants were also keenly aware of the need to practise in ways which were defensible and ensured that blame was not unduly passed their way, but which in turn were inherently confrontational and likely to result in an element of inter-team if not inter-professional conflict.

*"the way that health and social care is kind of divvyed up is that when something goes slightly wrong or horribly wrong there will always, a sort of blame game then ensues, so if somebody, is a 13 year old is in A& E and they've got no bed, and they've had no bed for three days and the local councillor gets involved and the local MP gets involved, I can turn around and say "the person has no bed, but there was an assessment on day one" whereas if an assessment hadn't happened, then there'd be a bit of a smokescreen about "oh, the AMHP didn't come down, and if we'd have knew that we needed a bed urgently, then we'd have done them, but we can't supply a bed until we know the outcome of the assessment" and that's a narrative that I've got very, very used for, used to"*

LA participant (integrated NHS team)

While a culture of blaming was influential in some participant narratives, overall narratives around conflict were far more closely linked to jurisdictional defensiveness or to participants' role as a discourse challenger. Not dissimilar to participants' own boundary setting, jurisdictional defensiveness was represented as other professionals setting similar restrictions around expectations of their role. While participant narratives reflected the same language of *"that's not my job"* (NHS participant, LA team) or *"that's not my role"* (LA participant, LA team) as applied to other professionals, participants were quick to distinguish these refutations from their own, offering rationales for why these positions were indefensible in the context of setting out statutory obligations, service expectations or

job definitions as laid down in policy. Such refusal to engage was positioned as a barrier to effective interprofessional working with subsequent detrimental impacts on service delivery and client relationships, and for some participants, represented a clear source of frustration:

*"Rather than trying to problem solve it, rather than trying to sort it out, it's like, "well, that's health's problem" or "that's the local authority's problem" and then that's the end of it. God, it's like, they're like children"*

LA participant (integrated NHS team)

While jurisdictional defensiveness was often posited in general terms to refer to relationships across services, the conflict arising from participant challenges to dominant narratives of practice was experienced very personally. Participants highlighted conflicts with identified individual practitioners rooted in highly emotive experiences which were *"distasteful"* (LA participant, co-located NHS team), led to them being *"really criticised"* (NHS participant, LA team) and, in one case, resulted in a *"prolonged verbal assault"* (LA participant, integrated NHS team). Central to this was a perceived criticism of a socially informed approach to practice. While participants still demonstrated a strong commitment to their discourse challenger role, there was a sense that, in order to maintain an ability to work collaboratively, for some participants there was therefore also a need to make *"small level adaptations"* (LA participant, integrated NHS team) to accommodate that.

Inter-professional relationships were not always challenging, however. For some participants, primarily based within NHS contexts, positive and constructive relationships with their immediate colleagues were a common feature of their experience. In this context, relationships were seen as more *"co-dependent"* (LA participant, integrated NHS team), with a more immediate awareness of individual practitioner contributions to the overall model of care. Supplementing this were indications that acceptance of the social perspective as a valid approach, meaning that *"there's quite a balance among the professionals between social focus and health focus"* (Third sector participant), was critical to effective interprofessional co-operation. Participants did not indicate a need for their perspective to dominate, but rather an expectation that they would be heard. Where relationships were not built on assumptions of role, approach or external influences, but

around shared professional understandings and objectives, participants spoke about them more positively

*"actually it's a very supportive team, you know, everyone supports, the coalface workers support each other very well and that, that's really good."*

LA participant (integrated NHS team)

## 9.3 Understanding mental health social work in context: locational factors influencing experience of the social work role

### 9.3.1 Organisational influence

Perhaps a challenge for maintaining positive interprofessional relationships was the extensive influence exerted by participants' organisations on their experience of undertaking their roles, with organisational context the single biggest wider influence on participants practice experience. Operationally, high levels of bureaucratisation were a critical impactor, with *"too much time messing around on our computer systems, ticking boxes"* (LA participant, integrated NHS team) to the detriment of what participants clearly saw as 'real' social work. This was a heightened challenge for participants in roles which crossed local authority and NHS organisational boundaries, who highlighted a lack of technological integration as a main recurring theme. The propensity for health and social care to operate using separate IT systems, with a lack of shared understanding and ownership proved a source of frustration for participants, primarily in relation to the barrier it represented in being able to work effectively and efficiently with clients and across professional disciplines.

*"We can't see, you know, even basic stuff like our email systems don't, you know, when, you know, when normally you type in a team member's name their email comes up. If they work for the NHS, it just doesn't come up, you know? We're only allowed to see, you know, we can't see each other's online diaries. It doesn't work. It's it, you know, it's just ridiculous."*

LA participant (integrated NHS team)

However, while such practical barriers most immediately impinged on participants' ability to enact their task-based roles, this technological divide seemed to represent a more ideological split for some participants, who noted this conflict reproduced across a range of criteria, including operational policies and managerial attitudes. Participants highlighted dissonance in policies around abuse of staff, funding of services, organisational professionalism, organisational service priorities and service user engagement. Where organisations worked with seamless integration, or effective workaround solutions, participants experienced a functional reality which did not feature strongly in their narrative around influences on practice, a trend that was very apparent in the accounts of the Third sector participants other than by contrast to previous practice environments. By contrast, however, where organisations operated independently, or in conflict with one another, this was a source of concern and confusion for those participants attempting to reconcile two conflicting sets of demands and, for some, an identity in two very different and distinct contexts:

*"To be honest, it is absolutely a nightmare. It feels like the council is my body, and my arm is mental health, and they've just chopped it off and threw it over there."*

LA participant (integrated NHS team)

Compounding these challenges from a practical perspective, participants highlighted difficulties in wider service structure and internal service limitations as key influencers in how they undertook both their substantive and their perceived professional roles. Participants described a service structure shrouded in mystery, with a lack of clarity around not only how teams were structured both externally and internally to their own organisations, but also in how individual teams operated. Linked to ideas of interprofessional confusion, participants struggled to position wider service structures in the context of their own roles, in terms of who to work with and how to work with them effectively, as one participant commented:

*"they are completely separate to us and knowing what their service entails, it's all sort of quite hush-hush and mystery; it's very, very difficult to get in touch with them and to actually get any feedback."*

NHS participant (NHS team)

Participants professional knowledge base was eroded by organisational context, particularly in their knowledge of structures. This left some participants unwilling to engage more widely with social work roles within their organisational contexts. For local authority participants, the idea of moving across local authority borders proved daunting in some cases, with concerns that *"I move over a team, it's two miles down the road, and it's completely different, what I do and what my roles and responsibilities are"* (LA participant, integrated NHS team). By contrast, for NHS contexts, the lack of definition in the social work role *within* teams, where roles were sometimes *"social workers titled, but they're just generic practitioners"* (LA participant, integrated NHS team) was an equal cause for concern. While some participants had taken steps within their own teams to address the lack of understanding around the wider service structure, this was invariably individualised and local to those teams, and the wider concerns around understanding service structures to maintain effective service provision and practice knowledge remained.

Resource limitations within services, linked primarily to the scope of service provision, were an experience that crossed organisational boundaries, Both NHS and local authority participants were acutely aware of the impact of reduced budgets and how this translated into operational practice as *"staffing issues"* (LA participant, co-located NHS team", *"not enough bums on seats"* (LA participant, integrated NHS team), *"funding issues"* (LA participant, LA team) and *"the lack of services"* (LA participant, co-located NHS team). These restrictive operational realities limited how they were able to undertake work in ways which were person-centred and holistic, and which explored alternative approaches to managing and addressing mental distress, leading to some degree of frustration:

*"So, what I kept finding was that my, my version of recovery, what my and my service user's version of recovery looked like was very different to what a skint NHS Trust version of*

*recovery, and they weren't even that skint to be honest, in [area], but it looked very, very different and I think there was a lot of talk sometimes and not much doing."*

NHS participant (NHS team)

Participants in all contexts were aware of these limitations, with local authorities described as *"creaking and straining"* (LA participant, integrated NHS team) and mental health services as in a *"terrible state"* (LA participant, LA team), and their impacts were felt almost universally. Statutory services were identified as overtaxed, and non-statutory services as under threat, with only a small number of NHS-employed participants operating in teams with specialised focus describing a working environment that was better resourced and more conducive to effective practice.

*"I feel very lucky to have the job I have, you know? I'm a bit loathe, bit loathe to say it, because it doesn't really feel like a social worker, does it? No, I mean, and it was an active decision of mine to go into forensic social work, because it's forensic, because it's- I know it's better funded than many other areas."*

NHS participant (NHS team)

Indeed, while participant accounts retained a strong focus on quantifiable and tangible characteristics of organisational structure and delivery, this was underpinned by an awareness of the conflicting priorities of local authority and NHS organisations. Participants saw local authorities as driven primarily by financial and budgetary concerns, both in terms of the individual budgets allocated to care, and more widely in the costs of providing a service, with a corresponding focus on the statutory obligations that the organisation held a responsibility to provide. This corresponded to a sense of scrutiny and accountability, which permeated the work that participants undertook with clients. While this was generally undisputed, attitudes toward local authorities framed them as *"rigid"* (NHS participant, NHS team) and *"quite unprofessional"* (LA participant, integrated NHS team) and participants did not engage fully with the local authority stance, with local authority provision more likely to be described in negative terms.

*"I think there is sometimes a sense of, you know, inefficiency and a level of bureaucracy and everything else. But I think that's kind of to be expected in, in local government."*

LA participant (co-located NHS team)

NHS priorities, by contrast, were presented as more provision-driven, with financial considerations seen as less relevant and service provision as a priority. For some participants this translated as *"the NHS represents social work values better than the local authority"* (LA participant, integrated NHS team), with an emphasis on service over cost aligning more closely with participants' professional narratives of person-centred and holistic practice. However, the self-alignment was not unquestioning or without reservation. For some participants, the NHS was *"a proper dinosaur…[that]…ties itself in corporate knots"* (NHS participant, NHS team) or, more forgivingly, showed *"their intentions are good but it just doesn't work"* (NHS participant, LA team). Medical dominance within health settings, and the sense that services were diagnosis led rather than client led, was a cause for concern for some participants who prioritised exploring alternative explanations and approaches to addressing mental health issues.

*"Going into a multidisciplinary team in the NHS where it was, I mean, it always has been, in my experience, very medical model heavy and you're the voice shouting sort of from the other side, like "hello?". So, I think that was quite, quite a change in culture of how, of how people work. I think it was getting used to the fact that people weren't always going to be thinking about, yeah, personal budgets or home life or, you know, work or like employment, things like that. It was a bit of a shock to come to a team where you'd be sat in a meeting and you might for half an hour just talk about should they be on this antidepressant or that antidepressant. That's not to say that's all we talk about, but sometimes it feels like that."*

NHS participant (NHS team)

These organisational factors came together to form an environment of uncertainty for practice; although the organisational contexts were widely varied on the surface, participant accounts reflected similar recurring issues across these settings; a complex service provision

within which mental health social work could be isolated, divided or forgotten. Despite this, however, participants were strongly divided in their views on the best approach for structuring and positioning mental health social work. Perspectives on integration and co-location were varied, and often contradictory, as the following accounts demonstrate:

*": I think it would be blurry if it was integrated again, because I feel like it would lose its… I feel we've got more social work identity now, probably than we would have done… if I was a lone social worker or one of two social workers like maybe yourself was, I feel like I'd feel like a bit of a silo within a, within a health team."*

LA participant (LA team)

*"There's not that kind of discord between health and social work, so I, you know, co-location works, co-location works, but not integration because there's always, always separate agendas. And until that disparity between health and social work is, is, is closed, um, it's always going to be the case."*

LA participant (LA team)

*"I know in another local authority next to [area] in [other area] that they have social work hubs for mental health, but they're not co-located. So, I think, how can you do the role of a mental health social worker if you're not co-located, you know?"*

LA participant (integrated NHS team)

*"I'd properly integrate with a section 75 agreement. I can't understand the arguments against that, really. I mean, I know the local authorities lose, they lose money, don't they? But that, absolutely, that's what I'd do. You would have happier patients, and you'd have happier staff."*

LA participant (integrated NHS team)

As these extracts illustrate, integration meant all things to all participants in all places. Local authority participants in separate teams were both simultaneously opposed to and in favour of integration, with the same dichotomy holding true for their counterparts within integrated settings and reflected by other participants. Participant views on separation, co-

location and integration were practically rather than conceptually or theoretically driven; participants rationalised their views based on their current or previous experience, whether positive or negative. Central to these understandings was the importance of 'what works' - delivering effective social work services - and therefore participant perspectives were strongly influenced not by their context, but by their personal views on what constituted effective mental health social work. For those participants who prioritised statutory obligations, separated or co-located services were the general preference. Conversely, where participants valued seamless service provision for clients, integration was the clear answer.

### 9.3.2 Physicality

While the organisation-as-context was an undeniably strong influencer on practice, physical location in a broader sense also played a fundamental role in how participants undertook their social work roles. At the micro level, and in the specific organisational context, this related to where practitioners were based as their practice location, a circumstance which had become more complex in the light of the coronavirus pandemic and the subsequent move to working from home.

Central to participant narratives about the value of the practice location was a sense of connection. Participants across all workplace contexts positioned 'the office' as a resource and a means of enabling collaborative work, rife with informal opportunities to work together, maintain and strengthen relationships and pool knowledge in a manner which improved the overall quality of the service being provided. In the context of the coronavirus pandemic and directives to work from home, this was seen as a lost resource, not easily replicated via email and telephone communication, which participants saw as more targeted, deliberate and planned. Although one participant suggested that the move to remote contact had worked effectively to reduce hierarchies within the team, the general consensus was that *"if I wasn't physically sat in that office my relationship with me, the people within the team would not be as good"* (NHS participant, NHS team). Participants felt that the more remote means of communication were less conducive to sustaining interdisciplinary and cross-disciplinary relationships.

*"it's when you run into each other and "oh yeah and regarding this client, I've seen them", so there's updating and just really which is the feeling of we're working together on something. Now you don't see them unless you send them an email and then it's a phone call, which usually is very task oriented. There is no such feeling like, yeah, we're working on the right direction, we're working together."*

LA participant (co-located NHS team)

The physical practice location was not seen as being without challenges, however. For NHS based social workers in particular, there was some concern that positioning within more medicalised services led to a weakening of social work cohesiveness and a devaluing of the social perspective in favour of a more medical dominated approach, with inpatient services identified as particularly challenging in that sense. However, this was not a problem easily resolved by physical separation, which although lauded by some participants as critical to maintaining social work uniqueness, risked contributing to higher levels of interprofessional misunderstanding, as one participant highlighted:

*"So, in theory, it was easier when we were kind of close by, because there would be that level of, kind of, conviviality, where people would be talking to each other and, and that did work. But as we disbanded, there's less of an understanding of what we're, what our roles are, I guess."*

LA participant (co-located NHS team)

Physical location influenced practice beyond the benefits and limitations of the practice setting, with the wider area playing a role in how participants undertook their work. For some participants, the use of geographic space across the areas they covered established a clear organisational hierarchy of importance, with those participants who worked in remote spaces or, in the case of local authority participants based in NHS settings, away from their parent organisation, there was a clear recognition of their needs being seen as "*second class"* (NHS participant, NHS context). This had clear implications for effective collaboration, as one participant explained in the rationale for why mental health social work meetings with the local authority had ceased:

*"They were in, they were in sort of like a central part of the city, but it was really inaccessible to get to, because it's on one of the main roads leading into the city centre. I don't know whether you know [area]. It's on, it's on [location], which is one of the main, busy, it comes in right off the motorway, basically. Yeah, so it's a busy, it's a busy, busy route and it would involve- so we cover [district], our team and where the meetings are held, there's two CMHTs based in that building. So it's just a case of walking upstairs for them for a meeting room and it was just- so it was accessibility issues"*

LA participant (integrated NHS team)

Similar to the significance of seeing specific clients in context in order to understand and work with them effectively, participants also acknowledged the need to adapt their own practice to the physical environment in order to operate in the most useful manner. While specific interventions themselves remained broadly similar across a range of contexts, participants saw value in using area-specific knowledge to inform how they practiced, both in terms of understanding and responding to need. Participants demonstrated understanding of the facilitators, threats and barriers which existed within different community settings, and were able to apply this knowledge pre-emptively in order to focus on relevant areas for assessment and useful strategies for intervention which were appropriate to the context in which they were working.

*"I think in cities you able to kind of blend in. You know, when you, when you walk around cities, obviously we'll recognise individuals and we know, but, you know, you're kind of, for the most part, unless you're highly visible with your mental disorder which you know is, is, in some cases, you're just kind of left alone to get on with it. Whereas I think in rural areas, you're more likely to be identified as such. And I think, you know, the, the high density of the population. It can be a blessing and a curse. Because obviously there's other people who you can, er, interact with who have similar needs to yourself, or alternatively, there's lots of people who will exploit you for your needs"*

LA participant (LA team)

This awareness did not facilitate, but rather demonstrated participants' holistic, outward facing focus, positioning clients in the context of their environments and responding accordingly. Participants for the most part did not see local knowledge as a pre-requisite to work in a particular mental health context, but they did recognise its value as a critical element of the role which would need to be developed quickly and efficiently.

Tangentially to this, participants recognised the practical limitations that location set on clients in engaging effectively with interventions. In particular, this linked more closely to the urban-rural divide than the NHS-local authority divide, with rurally based participants acutely aware of the limitations imposed in terms of access to transport and available services (and the corresponding time demands for participants) which impacted less significantly on their urban colleagues. For participants keen to practice in holistic and person-centred ways, this necessitated innovative approaches to practice which went beyond the conventional ideas informing service delivery.

Welsh participant accounts were distinct in this regard in relation to boundary working, explicitly with respect to the national border with England and the impact this had in particular for assessments under the Mental Health Act 1983. While the confounding factors of rural working in Wales mirrored those of corresponding rural areas in England, the nature of the surrounding geography frequently meant that the closest psychiatric inpatient unit to which a client could be detained was across the English border. With health a devolved matter in Wales, this added a level of bureaucracy to detentions which required a structured understanding of both the English and Welsh requirements for detention, although participants primarily framed this as not extending beyond an administrative burden.

## 9.4 Understanding mental health social work in context: structural factors influencing experience of the social work role

### 9.4.1 Formal frameworks

In the context of informing service delivery, and more directly individual practice, participants identified a number of structural factors which existed as a framing backdrop to participants' practice. These draw from societal, professional and organisational elements and were influential in considering participants' role within mental health settings.

Formal frameworks for practice in participant accounts were firmly rooted within legislation. Whether participants viewed statutory roles as integral or incidental to their practice, core pieces of mental health, social work and social justice legislation recurred continually in their accounts, with the Mental Health Act, 1983; the Human Rights Act, 1998; the Mental Capacity Act, 2005; the Equality Act, 2010 and the Care Act, 2014 forming the core legislative references for practice.

How participants prioritised these pieces of legislation was strongly influenced by their role and, to a lesser extent, their employment context. For local authority led participants, who held statutory assessment responsibilities, the Care Act 2014 took prominence, while for AMHPs and NHS-led participants, the Mental Health Act 1983 was their leading consideration, and there was a clear reflection of organisational roles and responsibilities in how participants prioritised each piece of legislation. However, regardless of the order of importance, legal frameworks occupied a position of primacy in participant accounts. They were seen as critical and essential adjuncts to practice, supporting participants in their task-based roles, with criticisms aimed more at how legislation was implemented and applied in practice, rather than the appropriateness of the legislation itself.

*"In terms of other bits of policy and legislation, I mean, I'm constantly thinking about the Care Act and Human Rights Act, and especially in custody thinking about the Human Rights Act because actually you can't always rely on the police to bear it in mind, to be honest, in my experience so far. Anyway, so I'm constantly thinking about that. Mental Health Act, obviously, Mental Capacity Act as well, but other than the kind of standard ones which follow us wherever we go"*

NHS participant (NHS team)

Welsh participants, operating within a differing legal framework, spoke of the Social Services and Wellbeing (Wales) Act, 2014 in contrast to the Care Act, 2014, but positioned this very similarly, with one participant with previous experience within English mental health services describing at as the Welsh version of the Care Act. The Mental Health (Wales) Measure, 2010 elicited mixed reactions from participants. Most frequently, this legislation was framed in the context of the explicit legal right to reassessment granted to former clients of secondary services, which participants highlighted as unique in the Welsh context. However, while one participant viewed this legislation as excellent, for the most part, responses were ambivalent, with one participant highlighting that a right to reassessment did not equate to a right for support.

"*We can reassess but that doesn't mean to say we're gonna accept someone back into services, but we need to at least assess them on multiple occasions, if that, if that's, if that's what they're requesting*."

LA participant (co-located NHS team).

By contrast, for the most part participants viewed policy as relatively inconsequential unless it had a direct and measurable impact on practice. While a small number of participants spoke positively about policy around mental health social work in principle, there was no clear indication of how this influenced their practice as mental health social workers, and participants familiarity and awareness of wider mental health policy on a national scale was vague and limited by comparison to their knowledge of legislation. In part, this reflected organisational attitudes to these policies; participants had no expectation that these would be *"discussed with me at work. I'd be absolutely amazed if anybody brought it up"* (NHS participant, NHS team) and depending on service remit, they were seen as *"quite a background thing"* (Third sector participant). However, compounding this was a sense of policy being detached and overwhelming, being *"wishy-washy"* (NHS participant, NHS team) in a manner that lacked direct relevance to practice and was more relevant to organisations to apply than to professionals.

*"I think I probably don't know enough about policies to have much of an opinion. And I think most of my experience comes from sort of service provision, which is obviously*

*watered down from government policy and legislation to the trust, who then makes decisions based on that information."*

NHS participant (NHS team)

National policy relevance was only seen where it could be directly linked to practice realities. Perhaps unsurprisingly then, the policies and guidance which held relevance for participants were those produced at the local and organisational level. Participants demonstrated much more detailed and in-depth knowledge of their organisational policies and guidance and were able to highlight areas where these were relevant to their practice. In this, policy became relevant for participants only after it had been interpreted, applied and contextualised from the wider abstract of the national vision.

### 9.4.2 Professional knowledge and skills

Although not a key theme for all participants, participants from across all contexts highlighted the significance of professional social work training as not only an influence in how they undertook their role, but as integral in informing how they did their role, by comparison to other professionals.

*"we are trained to have difficult conversations, we're trained to confront difficult emotions, we are, I think that we're trained to problem solve, to think on our feet. Whereas, you know, other professions within mental health are not trained, you know, they, they're quite, they're a little bit more boundaried in what they'll think about. They're prepared to, you know, think about problem and then stop thinking about, it reaches the parameter, whereas a social worker will just go out and out and out"*

LA participant (integrated NHS team)

Social work characteristics and specific skills were prioritised over specific social work models and interventions, which were mentioned, with only a few exceptions, in more abstract and limited ways. These characteristics, rooted primarily in social work values, were positioned as strengths in terms of how social workers operated, and how they were *"adaptive, flexible practitioners"* (LA participant, integrated NHS team) able to respond to

the unpredictable uncertainties of practice. For some practitioners, however, this indicated a need for caution, with adaptability posing a risk of being subsumed beneath medical dominance, while flexibility risked the diverse range of tasks social workers were completing going unnoticed within more structured and regimented services. In particular, one participant cautioned against a lack of focus and structure resulting in core social work knowledge becoming *"lost, forgotten, not, not apparently proposed"* (LA participant, integrated NHS team) under the more rigid frameworks of formal professional capabilities.

The lack of focus on social work specific models was perhaps rooted in participants' perspectives on their social work training which, for the most part, was critical of the extent to which they were unprepared to work within either the mental health or the practice specific contexts in which they found themselves. While value-driven characteristics worked effectively in informing the person-centred, socially modelled approaches that participants took to practice, the more practical skills and knowledge development was an area of training they, for the most part, felt had been underdeveloped and neglected:

*"I went to [university] and it was very political around, you know, the privatisation of mental health services. I get that, I don't agree with that, but when it comes to practice it wasn't helpful at all. But, unless you've got some experience, either as a student in a placement or something else, I think you really would struggle. You really would struggle."*

LA participant (integrated NHS team)

In terms of contemporary skills and knowledge development, participant experiences were extremely heterogeneous. Access to training and development opportunities was widely varied, depending on where participants were employed. As a broad trend, NHS trusts were seen as offering training opportunities more appropriate to mental health, while local authorities focused on social work specific training, but this did not hold true for all settings and both the scope and appropriateness of training opportunities available and the ability of participants to access these depended heavily on the participants exact practice context and local working arrangements, as these two conflicting accounts illustrate:

*"So, it feels like, to go back to your training question, it's just not really like recognized as something that is any different from what everybody else might need. So, for example, in my e-learning when I, when you start and you have to do all the e-learning stuff, there's a course on there about the mental health act, and basics of the Mental Health Act for nurses and I thought, "oh, why's that on my e-learning?". And they said, "oh, no, it's for everybody but you know we just called it for nurses". So, you end up taking courses that say it's for a CPN or it's for a nurse."*

NHS participant (NHS team)

*"I've had so much, you know, really good training as well. They put on like a, a training about, I think it was like a ten part training for us. So we learnt about psychosis, and kind of the support needs, support that's out there for people that we can refer them to, we had a dual diagnosis part, we had something on coaching and motivational interviewing, we had a session, it was like a roleplay but we watched it on the video and then we gave positive and negative feedback. And that was, that was really interesting"*

LA participant (integrated NHS team)

While participants valued their social work status and saw value in turn in being social workers in the specific mental health context, their experience of developing professional skills and knowledge was, by their account, at best partial and at worst ineffective in preparing them for mental health social work practice.

### 9.4.3 Support and development

At the organisational level, participants drew on two key aspects of the practice environment as background factors, namely the provision of supervision and the availability of development options. Although this had little direct identified impact on roles, participants did position supervision as critical overall and shared positive experiences of supervision across all settings, with a clear distinction drawn by both local authority and NHS participants on the importance of distinguishing between management and professional supervision. For NHS participants, in particular those managed by health colleagues, the criticality of social work supervision was emphasised, to the extent that a

number had negotiated dual supervision arrangements where managerial supervision was provided independently to social work supervision, and this was seen as an essential.

*"I think it's really important that I'm supervised by a social worker. I think there are potentially some roles where a nurse could provide management supervision to a social worker, but I think it is really, I think this is what keeps the professional, that golden thread of the professional, alive, is having that contact directly with a social worker."*

NHS participant (NHS team)

However, even within a local authority context, there was an acknowledgement that divorcing managerial supervision from professional case discussion was beneficial, in terms of separating the organisational responsibility from the professional reflection and enabling space for participants to explore their decision-making independently of the pervading culture of accountability.

*"Peer support, working with [social work colleague] – she's the grade eight - it really has brought me on leaps and bounds practice wise, that's more of an informal basis because she sits next to me. And we talk on a day to day basis about cases and she leans on me and I lean on her. So, that's really helpful."*

LA participant (integrated NHS team)

Where one to one supervision was deemed to be ineffective was when organisational expectations and managerial responsibilities took precedence over participants' opportunity to reflect on and develop from their practice experiences. Supervision provided across professional boundaries represented such fundamentally diverse starting positions that one participant equated this to being supervised by an *"empty vessel"* (LA participant, integrated NHS team), with a lack of shared understanding of the social work role and contribution impacting detrimentally.

*"In a previous team. I was supervised by a health professional who didn't understand the difficulties that are hard in relation to my role and it was very, I felt very much deskilled in relation to that, you know"*

LA participant (LA team)

For some NHS-employed participants, there were particular challenges in sourcing social work supervision, even when they were employed specifically as a social worker. Although some participants in this context found their supervision needs well catered for, others found themselves adrift, with responsibility for sourcing social work specific supervision not prevented by their employing NHS trusts, but also not facilitated in turn.

*"I mean, I just got an email basically saying, like, make sure you find a supervisor. Which when you start in a brand-new area - like I said, I knew [colleague] and that was it - was quite daunting, because I was like, how do I even find these people? Like I wouldn't have a clue where to start, to be honest about finding anybody"*

NHS participant (NHS team)

By contrast to individual supervision, group supervision and peer support elicited a more lukewarm response from participants. With the exception of one local authority participant, who valued the opportunity to discuss cases in a group context, participants spoke extensively of group social work sessions that they did not attend, or were not interested in which, in turn, in many cases had ceased to be delivered. Participants did not see these sessions as valuable for a range of reasons, although a central thread to these appeared to be the lack of specific focus which would have rendered the sessions specifically useful in their practice context. These reservations related to both the structure and delivery of the sessions as well as the content, and a recurring theme of participant accounts identified successful peer support opportunities as those which were organised and led from grassroots practitioners rather than top-led through organisations, which participants frequently framed as a time-wasting activity:

*"it was just a bit of a talking shop, you know we'd asked for "Can't we get someone from direct payments, for example, or from commissioning?". You know, can we find out about x, y and z, can we have a senior manager come in, so they can tell us about service changes? And in the end it was the same team leader running the meeting, saying "I'll put that down in the agenda." it was just hot air and bluster really"*

LA participant (integrated NHS team)

While participants were generally positive about some aspects of their supervision support, development opportunities exerted far less influence over their practice realities. This related in part to the limited opportunities for development that participants identified and, correspondingly, their views on those particular opportunities. Statutory roles, most notably to train as an AMHP, and management routes offered the two distinct pathways for social work development, and participant attitudes toward development opportunities were heavily influenced by whether these roles fell within their own personal development objectives.

*"Talking about ourselves as social workers within adult social care, but within the kind of the AMHP role, so really thinking about, for my practice, around, you know, shadowing AMHPs. I'm talking about being part of the AMHP pathway at the moment, to look at whether that's a possibility for me and my development within mental health social care."*

LA participant (co-located NHS team)

Views on the AMHP role were divided however, with a substantial number of participants disinterested in pursuing this role, while those who had pursued it still expressed concern that, having achieved the AMHP qualification, *"there is no progression, unless you want to go into management"* (LA participant, LA team). Despite evidence suggesting that social workers were over-represented in management roles (Best and Williams, 2019; Workman and Pickard, 2008), these were almost universally rejected by participants; while a minority either already held management roles, or expressed an interest in exploring that route, for the most part, participants expressed unwillingness to take that step away from direct work with clients in favour of increased involvement with organisation bureaucracy. Professional development opportunity, from an organisational perspective, in mental health social work as a distinct discipline was absent in all practice settings and contexts.

*"That's it, I'm done, and I've said to, I've said to my partner, like, "what, what can I do next?" Like I'm, I'm three years qualified, next year I'll be four years qualified and I've got*

*to the end of the social work ladder. Like, what do I do? There's nowhere else I can go. Have you got an answer for me please?"*

LA participant (LA team)

Critically, development was often linked to the employing organisation. For NHS-employed participants, there was a mixed experience in terms of being able to access training and development linked to conventionally social work roles, such as the AMHP, but correspondingly, local authority employed participants frequently struggled to access broader skills development, particularly in terms of therapeutic skills, where this was seen to extend beyond the social services remit within mental health:

*"I did at the time actually ask for specific training - this is when I was a practitioner, this was - I did actually asked for specific training, like therapeutic led training really just to try and make me more confident, competent really in my role, really, but…it was a diss, it was a bit of, on the one hand, although we were expected to take up generic work, on the other hand, the senior management from social services was unhappy about us going on training which was deemed as not a social work. So it was, it was stupid, yeah."*

LA participant (integrated NHS team)

## 9.5 Conclusions

The findings of this chapter aimed to illustrate the impact of wider factors related to the employment setting on how professional roles were seen and enacted in practice. Wider factors impacted on participants' conceptualisation and undertaking of roles in markedly different ways. Relational factors saw viewing clients in context as integral to how participants across all settings undertook their roles as holistic and person-centred practitioners, and in this their accounts held high levels of congruence regardless of context. By contrast, interprofessional relationships directly impacted on participants' efforts to work collaboratively, posing a particular issue for NHS-based participants, with misunderstanding or disregard of the nature of participants task-based roles a source of concern. Conflict, rooted within practitioner roles in challenging dominant discourses and a perception of other professionals restricting their own professional roles illustrated the

ways in which participants' roles interfaced with wider practice factors to create an internal dissonance, where working collaboratively but also challenging and promoting a social perspective were not necessarily compatible.

Locationally, the organisation-as-context impacted participant roles across all three roles categories and was framed almost exclusively negatively by participants, with positive sentiments usually positioned as a comparator for criticism for an opposing organisation. This is not to say that participants experienced their organisations in solely negative lights; rather that the influence of organisation on role was primarily negative or, presumably neutral. Organisations appeared to act as a space where participants could practice unhindered, or to pose a barrier to effective professional work as participants had positioned it. Ineffective tools for practice impacted detrimentally on participants' ability to fulfil task-based roles, while oblique service structures reduced opportunities for collaborative working and minimised participants as 'knowers' of social structures and processes. Resource limitations restricted the capacity for person-centred and holistic work by limiting the extent to which practice could be innovative and responsive and drove traditional, more bureaucratised, more medicalised ways of working in some contexts which could minimise participants social perspectives. By contrast, the physical environments of practice were markedly less intrusive. Although the specific impact of the coronavirus pandemic impacted on collaborative working in a negative fashion, this impact was linked to working from home in isolation, rather than as an influence inherent in the setting. Similarly, in this context, structural differences and barriers built into communities were an opportunity for participants to showcase their holistic perspectives.

Structural factors linked to role in a less distinctly influential way, providing more of a bedrock upon which participants built their distinct social work identity and constructed their professional selves. With the exception of the formal legislative frameworks for practice, which potentially held direct relevance to participants' roles as organisational and statutory agents, dependent on specific context, social work knowledge and skills and access to support and development were framed more as necessary to support social work within

mental health as a whole, while their contribution to any specific given role was more limited.

# Chapter 10: Discussion

## 10.1 Conceptualising an overview of the findings

Positioning mental health social work within its practice context necessitated a multidirectional approach to exploring both physical and conceptual positioning with the existing mental health service structure. Investigating mental health social work in isolation risked neglecting the diverse practice contexts which had developed in response to the organic development of the profession (Lilo, 2016). By contrast, considering only the practice context in turn would have paid insufficient attention to the variety of individual roles that can exist within even a single organisation (Tucker and Webber, 2021). Acknowledging the inherent restrictions on health and social care research in the context of the strain of the coronavirus pandemic, this research sought to address that variety by exploring the practice context on a national scale, gathering an overview of mental health social work perspectives and engaging in a detailed exploration of those perspectives with mental health social workers who represented a broad range of practice roles and settings.

It is in this aspect that this research offers a new and unique contribution to the understanding of mental health social work practice. While previous studies have acknowledged the importance of context such studies have often been undertaken as single site (Tucker and Webber, 2021; Bailey and Liyanage, 2012) or across a limited number of sites (Abendstern et al, 2021). The extent to which understandings of role in those contexts can be applied more generally across the mental health social work workforce have, by necessity of design, been limited. The universality of role definitions in mental health social work have been internally challenged (Tucker and Webber, 2021), with a clear unwillingness to accept external definitions which are not seen to 'fit'. By positioning practice context as central to understanding role and adopting a nationwide perspective across two nations of the UK, this research contributes to addressing this disparity. In line with previous studies (see, for example, Abendstern et al, 2021; McCrae et al, 2014; Allen, 2014), it aimed to generate a framework for understanding mental health social work which was driven from within the profession, thereby mitigating against rejection rooted in professional defensiveness (Hannigan and Allen, 2011). However, it also sought to explicitly position that

understanding within practice contexts in order to ensure that central elements which applied universally could be incorporated into the framework for understanding, while those which were not universal could be appropriately limited. In doing so, the research has established a framework which explicitly incorporates contextual influencers on role and is in turn able to mitigate against these, thereby proposing an understanding of mental health social work which is more robust to rebuttals from practitioners due to lack of relevance (Tucker and Webber, 2021).

Having established and outlined this position to this point, consideration now turns to articulating that positioning as an overall understanding of the mental health social work role. This chapter will first consider the implications of the findings relating to the structure and deployment of the mental health social work workforce, before subsequently positioning that workforce in the context of its roles and perspectives with an integrated exploration of the findings from the national survey and corresponding interviews. Drawing on these explorations, the discussion then moves to the development and proposal of a model for understanding how professional role is constructed in the context of mental health social work amidst a rich and diverse range of practice settings and responsibilities. Finally, a consideration of the strengths and limitations of the research will be presented, along with implications for policy and practice and recommendations for further research.

## 10.2 The social work workforce

### 10.2.1 The overall structure of mental health social work

Previous estimates of the mental health social work workforce, where they have existed, have been incomplete and broad ranging, making understanding how they could be used effectively in planning wider service provision challenging (Trewin, 2019). Without a clear picture of where and to what extent social work exists within mental health service provision, it becomes challenging to plan an effective and impactful use of that workforce in the current and future delivery of services. The high response rate in this aspect of the research provided a more robust understanding of both how and where this professional group is deployed and employed, supporting workforce planning aspirations more widely

than at a local level and offering a timely contribution in the context of the wider policy focus on the restructuring and redesign of the mental health workforce more generally (NHS England, 2021; Welsh Government, 2020). Subsequent work by NHS Benchmarking (2020) addressing a similar question around the structure of the workforce for England returned consistent findings in terms of the NHS-employed social work workforce, although the impact of the coronavirus pandemic precluded similar comparative work with local authorities. While not definitive, this does suggest that these findings on workforce structure reflect the practice reality of the complex composition of mental health social work.

The lack of overarching structure to service provision evident in previous research was similarly reflected here (Wilberforce et al, 2015; Burn and Lloyd,2004). Social workers were widely employed within both local authority and NHS settings, with no clear preferred model of practice emerging within any given context. This corresponds to assertions that provision is ad hoc, driven by local priorities, relationships, and conventions rather than by a more comprehensive plan (Evans et al, 2012). It also reinforces perceptions that workforce planning is health focused to the exclusion of social work (Anderson et al, 2021), reiterating the position of mental health as more health-based and medically dominated (Beinecke and Huxley, 2009). It could be suggested that austerity drivers, and the removal of local authority social workers from NHS contexts (King's Fund, 2015) may be an influential factor in the number of social workers being employed directly within the NHS rather than their traditional local authority settings. However, this presumes an increase in the number of social workers employed in NHS contexts. As this figure remains unreported in the NHS workforce statistics (NHS Digital, 2022), such opportunities for comparison are rendered non-existent and the supposition cannot extend beyond a hypothetical at this stage. Regardless, in this research a mental health social work NHS workforce was not consistently seen on a national scale in England or Wales. Instead, provision appeared haphazard, drawing on local conventions and existing practice structures rather than being driven by any informed concept of the social work contribution (Allen et al, 2016). This represents a pragmatic approach, driven by circumstance, but risks a 'postcode lottery' provision. Service user experience becomes dictated more by their location and the local offer than their identified or personalised need. This could be argued to run directly contrary to

current mental health policy (Welsh Government, 2012, HM Government, 2011) and the personalisation and wellbeing agendas which underpin social work (Welsh Government, 2016a; 2016b; HM Government, 2007).

### 10.2.2 Mental health social work provision in the context of the wider societal structure

Such 'postcode lottery' type risks were made evident in the inconsistencies in mental health social work provision by comparison to the respective local populations. Provision per capita was notably variable across the regions, with provision in the North East at one end of the spectrum almost twice as high than in the East Midlands at the other. Broadly speaking on a surface level, the provision of mental health social work did appear to relate to the corresponding population, but the wider rationale for these levels of provision remains unclear. Figures made available by Social Work England (2022) suggest the provision of mental health social workers, in terms of raw numbers of staff, broadly corresponded geographically with the wider social work workforce. This again suggested a correlation with local population size, although such a comparison should be viewed cautiously given differences between how location was recorded in this research and in the regulator's figures. Correspondingly, nonetheless, given the extent to which local authority funding is dictated by local income, and therefore directly impacted by population size (Atkins and Hoddinott, 2022), there is a logic in noting the similarity between population size and levels of social work provision.

Such observations should elicit a note of caution more generally, however. General population figures are arguably a crude measure to use to dictate the level of service provision, as they do not necessarily correspond to the regional level of mental health need (Pieh et al, 2021; Wilkinson et al, 2007) which is likely to be contextually driven. Although such data at a regional level is not routinely available, the evidence which exists suggests that local need appears variable both over time and across regions, differing to population spread (Pieh et al, 2021; Baker, 2020; Wilkinson et al, 2007). These variations did not appear to correspond to the variation in provision demonstrated in the findings here, in turn indicating that, despite earlier considerations of a localism agenda informing service

structure (Hannigan, 2022; NHS England, 2019a), current service design is not driven by an assessment of local need.

### 10.2.3 Mental health social work provision in the context of the organisation

While service design appeared to be more a matter of accident than design, variations were noted between local authority sub-types and both the number of social workers employed and the nature of the relationship with NHS partners. While it is beyond the scope of this study to draw conclusions about the nature of this association, it should be considered that local authority sub-types often reflect the areas they serve, with county councils usually covering larger, rural areas while unitary and metropolitan authorities serve smaller, more densely populated communities (Ministry of Housing, Communities and Local Government, 2019). Where there is a larger population to be served or a wider geographical area to be covered, it seems plausible to consider that this might impact on staffing provision in a localised approach to service delivery. While not definitive, this correspondingly could indicate a locally prioritised approach to some extent as previously identified (Evans et al, 2012).

### 10.2.4 Mental health social work provision in the context of history

Indeed, it should not be forgotten that service provision driven by local need has been a focal element of healthcare provision in recent years (Hannigan, 2022; Wilberforce et al, 2015). The Cameron era of 'Big Society' privileged localised approaches at the expense of a national overview (Scott, 2010), while Welsh policy at the point of devolution targeted this (Hannigan, 2022). By extension, it should perhaps be expected that this would produce a diverse workforce structure which would become practically indecipherable when scaled to a national level.

To accept this as an explanation, however, falls short when taking a temporal view of the development of mental health social work. As previously established, a closer interrogation of mental health policy over the last hundred years establishes both the lack of a consistent approach and contradictions in guidance and objectives which are not easily explained by a

focus on localism. Fluctuations between specialism and genericism (Welsh Government, 2012; HM Government, 2011; Department of Health, 1999) and the separation and integration of social work and health without clear rationales (Wilberforce et al, 2016; Rummery, 2009; Carpenter et al, 2003) speaks to a more ideological than evidence-based approach to service provision. Equally, the absence of social work as a consideration across mental health policies suggests more a lack of forethought and planning than an intentional local focus, while the lack of evidence to link levels of need and levels of provision does not support the model of a variable service structure born from the policy focus on localism (Hannigan, 2022; NHS England, 2019b). The structures of provision identified in the research indicate that this is driven more by local necessity than local intention. The ongoing organic development of mental health social work means it by necessity fills the gaps left unidentified in wider mental health policy, reacting to the societal influences surrounding it but potentially without the specialist knowledge to inform this (Fitzpatrick et al, 2020). Lacking direction from policy leaves mental health social work resembling less a well-tended and structured garden and more the haphazard chaos of a wild meadow.

### 10.2.5 Conclusions on mental health social work provision

Understanding how social work contributes to mental health provision in the context of a unified professional identity is challenging where this rationale and framework for input is unclear at a structural level. These findings offer a snapshot of mental health social work provision pre-pandemic but indicate no dominant pattern of service structure, suggesting that there is no clear sense of which approach is most effective and, perhaps, no clear model of what form 'effective' service provision might take. Correspondingly, the dominant approach seemingly continues to be one of convention and pragmatism, with mental health social work provision being dictated primarily by the resources available and the precedent of what has come before (Evans et al, 2012; Freeman and Peck, 2009). Such a position arguably limits the optimum use of social work resources to achieve the best outcomes for service users. While it may be understandable in the absence of a clear evidence base for effective input, this suggests that further investigation is needed to build a better understanding of 'what works' rather than an acceptance that 'what works' has been superseded by 'whatever we've got'.

In this context, the findings from the initial stage of the research provide two things: a robust benchmark for understanding provision, which can be used both for understanding the current workforce, and as a comparator for future developments in service delivery. High response rates enabled a reliable estimate of the scope and structure of mental health social work and, in turn, provided a contextual landscape within which to position and understand the contribution that social work makes to mental health provision. Such an understanding is evidently necessary to facilitate more targeted service design moving forward

## 10.3 The social work perspective and contribution

### 10.3.1 Robust representation: the internal strength of mental health social work identity

A profession which has struggled to articulate itself (Bogg, 2008), in the context of this diverse and variable practice structure which necessitates transdisciplinary working and subsequent role blurring (Emprechtinger and Voll, 2017), might have been anticipated to hold a poorly defined sense of professional self. Acknowledging the extent to which theoretical understandings of role identity are rooted in the interaction of self and space (Rasmussen et al, 2018; McCrae et al, 2014) and authenticated through the external rather than the internal gaze (Wolfensberger, 2011b; Ashcroft et al, 2008; Hughes 2001), the absence of an overarching vision for the provision of mental health care more widely, and mental health social work specifically, was prospectively a hostile context for developing a strong professional identity. However, this expectation did not come to fruition. Despite repeated suggestions in the literature of social work as an underdeveloped semi-profession with a weak professional identity (Bailey and Liyanage, 2012; Sims, 2011; Toren, 1972; Etzioni, 1969; Queen, 1922) and detailed accounts indicating the influence of external professionals (Emprechtinger and Voll, 2017; Wolfensberger, 2011b) and organisational contexts (Ashforth et al, 2008; McCrae et al, 2007; Ashforth and Mael, 1989) participants in this research demonstrated a strong sense of professional identity which was consistent and coherent across professional contexts. Participants ranked this identity as highly important, even in light of the clear narratives evident in their qualitative accounts regarding the

potential for their professional input to be disregarded or openly challenged. In contrast to the theoretical conceptions of professional identity positing a necessity for internal engagement and external validation of professional self (Best and Williams, 2019; Elvey et al, 2013; Wolfensberger, 2011b; King and Ross, 2004), participant narratives reflected criticism and challenge from the health 'outgroups' (Ashforth and Mael, 1989) as a validation rather than a condemnation of their professional identity. Deviance from the dominant health narrative, rather than serving to devalue their professional role (Wolfensberger et al, 2011a) appeared to serve as a validation. Instead, participants relied primarily on personal constructions of professional self, with professional identity seen as distinct from personal identity but still most heavily influenced by individual and internal factors: values, knowledge and skills and individual roles. External influencers, namely professional standards, wider organisations and perceptions of the profession were deemed to be of least importance, with the implication that participants did not experience a need for external endorsement of their professional status.

This is perhaps not surprising specifically in the mental health context within which these participants operated. One of the critical differences noted during the qualitative interviews was in the different experiences of those participants in local authority settings versus those in NHS settings in relation to operating as internal challengers to both their organisations and the internal professional colleagues they worked alongside. For those participants in NHS contexts, the rejection of dominant internal narratives formed a staple of the practice environment and was the cornerstone of their established role as challenge agents. Drawing on Evetts (2013) conceptualisation of the organisation as professional may to some extent explain this. While Evetts' position was intended to encapsulate the bureaucratisation and standardisation of professional roles, it simultaneously posits the organisation as holding a similar professional status to the individual. On this basis, the same rules of internal acceptance and external validation would arguably hold true. To invert the interpretation of the social worker as the 'troublemaker', rooted in a deviant identity (Tucker and Webber, 2021; Wolfensberger, 2011a), instead, from the perspective of those social workers, it is the organisation which is divorced from social work priorities and aims that becomes the deviant and devalued identity. Correspondingly, in line with social role valorization, the deviant organisation is minimised and excluded (Wolfensberger,

2011a; Osburn, 2006). In the context of professional validation, the value of authentication from a spoiled source is arguably diminished.

A similar devaluing of the outgroup identity was evident in participants accounts of their interactions with professionals in other disciplines, most commonly health. While participant narratives of disempowerment and disadvantage in their interprofessional relationships corresponded with existing literature around a lack of professional distinctiveness and the corresponding inherent power imbalance (Dent, 2017; Emprechtinger and Voll, 2017; Weiss-Gal and Welbourne, 2008), participants' insistent positioning of themselves as compelling challenge agents and discourse challengers, combined with their strong sense of professional identity more broadly, suggested an alternative interpretation. Although participants were prepared to acknowledge and respond to their inherently disadvantaged position as outsiders (Beddoe, 2017), they were equally unprepared to accept this as the status quo. Instead, outgroup professionals with conflicting narratives were positioned as misinformed or unaware and participants did not engage with ideas of their own identity as being in some way devalued (Wolfensberger, 2011a).

### 10.3.2 Mirror images: the multi-faceted nature of mental health social work identity

A similarly limited relationship was observed with regard to conceptualisations of professional roles. McCrae et al's (2004) typology of the genericist-eclecticist-traditionalist, which suggested a lack of consensus among the profession on where its primary focus should lie was not replicated in this research. Instead, participants adopted a range of aspects to their identity which embraced both mental health and social work with equivalent enthusiasm (Elvey et al, 2013). When presented with a choice between the three elements of identity (mental health worker as genericist, mental health social worker as eclecticist and social worker as traditionalist), participants opted instead for a hybridised identity. Rather than viewing the categories as mutually exclusive, participants identified strongly across all three aspects of identity, demonstrating a clear lack of distinction between the different elements. This manner of hybrid identity resonates with Woodbridge-Dodd's (2017) conceptualisation of discourse positions adopted by AMHPs in

the enactment of their duties. Critically, within those discourse positions, AMPHs were not fixed to one presentation of professional self. Rather, movement between the positions was fluid and informed by the nature of the work being undertaken at any given time. While those positions were envisaged by the author as distinct from roles, that sense of fluidity as a feature rather than a flaw may be relevant to conceptualising the multi-faceted identity that participants in this research embraced. Instead of viewing professional identity as fixed and immutable, these findings suggest a more inclusive approach which enables professional identity to incorporate aspects from a range of perspectives and contexts which come together to inform the whole (Elvey et al, 2013; Sims, 2011). Effectively, this supposition argues that mental health social workers can adapt identity to context, prioritising either social work or mental health identities depending on circumstance and necessity. Conceptually, this helps to explain the multidirectional nature of the mental health social worker as knowledge specialist identified in participant interview narratives, positioning the mental health social worker as a social worker when facing health settings and a mental health worker when facing local authority settings, offering appropriate knowledge or challenge to fit the circumstance.

### 10.3.3 Identity in context: the relationship with the practice setting

This identity fluidity may help to explain why the aspects of professional identity appeared to have a tenuous relationship with the various practice settings. With the exception of the social worker identity, where a statistically significant difference was observed between participants in local authority and NHS settings, there was no observable relationship between identity and practice context, refuting Webb's (2015) suggestion of an inextricable link and the swathe of literature which draws similar connections (Rasmussen et al, 2018; McCrae et al, 2014; Ashforth et al, 2008). Indeed, while it is not possible to draw causal relationships from the findings of the survey, when viewed in the context of the qualitative findings, it might be suggested that the historic link between social work and local authorities, combined with the narrative of minimisation within NHS settings evident in participant accounts offer an explanation for why local authority based participants engaged more closely with the social worker identity. In NHS contexts, mental health social workers

still saw themselves as social workers, but the space for social work was less clearly defined than in the profession's traditional local authority base (Beddoe, 2017).

While this congruence between the quantitative and qualitative aspects of the research offered insight into the inclusive nature of mental health social work identity, perhaps more interesting was the extent to which the statistical analysis of the survey findings and the thematic analysis of the narrative accounts did not correlate in relation to the extent of organisational influence. Although the narrative accounts showed a clear connection between the organisational context and different aspects of the social work role, no such corresponding influence was evident in the measures of practice environment administered in the survey. The PES-NWI (Lake, 2002) and the Culture of Care Barometer (Rafferty et al, 2015) both demonstrated a high level of congruence across their scores, albeit with some notable differences which are worthy of mention.

For the PES-NWI, overall scores showed no statistically significant difference. Although local authority employed participants returned a 'mixed' overall score by comparison to 'favourable' scores for all other practice context groups (Lake and Friese, 2006), these results should be interpreted with caution. Acknowledging the low threshold set for a favourable score (Lake and Friese, 2006), the application of the measure across multiple practice settings minimises the extent to which this classification can be held to be meaningful, as this approach to interpretation is predicated upon the measure being administered in a single practice setting. The Kruskal-Wallis H-test, therefore, demonstrates a more useful comparison in the context of this research (Corder and Foreman, 2009). Where differences did occur in the PES-NWI scores these demonstrated that NHS social workers in all aspects of practice settings valued health relations higher than their local authority counterparts. This is perhaps unsurprising, given the significance of internal relationships with health staff also evident in the qualitative findings. NHS-managed participants also valued health relations higher than those managed in other areas of practice while, conversely, they felt less involved than those managed in other settings and less influential in quality of care than their local authority counterparts. Again, these variations may potentially be explained by the narrative of minimisation shared by

participants in NHS settings, reflecting Beddoe's (2017) positioning of social workers in health contexts within a conceptual framework of guest and host.

The Culture of Care Barometer (Rafferty et al, 2015) was also largely congruent, although local authority-managed participants as a group gave a higher score for the overall culture of care in their practice contexts. Scores from the individual subscales may help to explain this; local authority managed participants scored statistically higher than their NHS partners in being informed, experiencing positive management and having access to training and development, linking again perhaps to the significance of the local authority as a social work space (Carey, 2015). Participants seemed to demonstrate feeling more involved in the workings of the local authority, which was arguably structured more specifically around their needs as a workforce, by comparison to the NHS where healthcare work is the central consideration, with social work more an addendum (Beddoe, 2017). Interestingly in light of this interpretation, NHS employed participants felt more engaged and involved than their local authority counterparts. While this may seem contradictory, it does reflect both their positioning within the primary partner in mental health service provision (Lilo, 2016) and the reported levels in the narrative accounts of poor communication between local authorities and NHS trusts. While local authority participants felt better engaged with their organisations, NHS participants seemed to feel better engaged in the operation of mental health services, where the local authority exists more on the periphery. Overall, this range of findings indicates a complex relationship between management and practice environment which does appear to resonate with participant narratives around the complexities linked to integration, service structure and service provision. Nonetheless, despite these differences, the overall congruences between the expressed experiences of the groups within the survey is evident across both practice measurement tools, and both returned broadly favourable results in line with other practice areas (Rafferty et al, 2015; Lake, 2007).

This congruence contrasted sharply with the findings from the participants' narrative accounts. In the narrative context, the health relations which were identified as valuable in the PES-NWI were expanded upon in ways which presented them as predominantly challenging. The criticality of cross-disciplinary working was made apparent through the

collaborative agent role, however, interprofessional relationships were conceptualised as difficult, underpinned by jurisdictional defensiveness (Elston and Holloway, 2001), misunderstanding and conflict, reflecting the recurring narratives in the existing literature (Best and Williams, 2019; Joynes, 2018; King and Ross, 2004). The organisation-as-setting was identified as influential across all dimensions of the mental health social work role, with an emphasis on the negative aspects of this which reflected the interprofessional challenges. Organisations in these accounts were framed as adverse or, at best, neutral spaces. This reflected wider narratives of abandonment (Phillipowsky, 2018; Bailey and Liyanage, 2012), and poor workforce morale, especially in the cross-agency context (Coyle et al, 2005; Reid et al, 1999), but stood in direct contrast to the survey findings, which positioned organisations as neutral or favourable.

Key to understanding this apparent dissonance is a more detailed consideration of the roles identified within the participants' accounts. By contrast to existing conceptualisations of role, which focus on a subset of tasks (Dwyer, 2005; Morgan, 2004), or specialist social care knowledge (Abendstern et al, 2016) or values (Goemans, 2012) or boundary positioning (Oliver, 2013), participants in this research adopted a multi-faceted stance, drawing elements from each of these positions to generate a conception of role which demonstrated a combination of the practical, the ethical and the esoteric elements reflected across the previous conceptualisations.

#### 10.3.3.1 Conceptualising the task-based roles in context

Task-based roles were practically focused. They positioned participants at the boundaries and interface of services (Oliver, 2013; Nathan and Webber, 2010), with an emphasis on both team working and team building, while also centralising the organisational tasks and statutory duties prioritised by their employing and operational agencies. Gatekeeping and facilitating access to services, direct provision of interventions and support in line with their specific service remits and structural implementation roles were all conceptualised around fulfilling the needs of their respective services and, as such, were highly sensitive to practice context. Variation by practice setting was therefore seen across all dimensions of these roles. Technical specialisms were prioritised (Canavan, 2009), leading to a heavy emphasis

on social work legislative expertise and a careful rejection of medical expectations, in particular around legislation.

These task-based roles were outward-facing and externally defined, principally by the participants employing organisation or by the organisation where they undertook their substantive role. It is notable here that the existing policy definitions of social work roles (Allen et al, 2016; Allen, 2014) emphasise the things that social workers in mental health will *do* – fulfilling statutory obligations both within and external to the AMHP role, engaging with communities, managing complex risk and promoting recovery. With the exception of recovery, which was conceptualised in previous research as a values-based perspective that had been standardised and proceduralised to become a task of care (Tucker and Webber, 2021), these existing roles begin from a task-focused stance. By necessity therefore, they too become outwardly defined and in need of external validation, and, in keeping with Weiss-Gal and Welbourne's (2008) definitional categories for social work professionalism, the more difficult areas for social workers to effectively establish a consistent professional identity. Viewing the areas of variation in the survey findings through this lens of external definition, it becomes apparent that these occur at points where participants interact with their organisational environment – in accessing information or developmental support, in interacting with colleagues and management, in establishing influence and in impacting on the delivery of services. By contrast, congruence occurs exclusively in those areas where the practice environment interacts with the participant, in terms of leadership and management input, support offered from the team or the wider resources available to organisations. Where participants sought input, there was divergence, where participants were offered input, there was congruence.

The external definition of task-based roles may also explain to an extent the disconnect seen between the policy-based definitions of mental health social work (Allen et al, 2016) and mental health social workers lived experience of practice (Tucker and Webber, 2021). Task-based roles were influenced by professional standing as social workers but primarily defined by organisational necessity and led by organisational priorities, positioning the organisation as a critical component of the helping relationship in line with Davies (2021) maintenance theory of intervention. As a result, these roles were heavily influenced by the wide diversity

in service provision identified in the earlier phase of this research. The variety of social work roles within teams in turn necessitated a similar level of variety in the organisational tasks they were expected to undertake, the legislative duties they held responsibility to meet and the extent to which they collaborated within and across services, as informed by their substantive role.

The extent of this variation arguably challenges any attempt to create an inclusive definition of the mental health social worker which centres around what social workers *do.* As participants in this research highlighted, what social workers *do* is heavily contingent on *where* social workers operate and in what capacity. This perhaps explains the disconnect explored earlier in relation to the seeming lack of influence of the organisation on professional identity in this context, in direct contradiction of the existing literature (Rasmussen et al, 2018; Ashforth et al, 2008; McCrae et al, 2007). Positioning of professional identity as something both self-defined and situationally defined (Ashforth et al, 2008) becomes more congruent with the findings of this research if the accepted definition of that identity is rooted within the policy-driven, task-focused framework (Allen et al, 2016). While the categorisations of mental health social work tasks were more universal, where identity is inextricably linked to task, these identities will by their nature by heavily influenced by the practice environment. However, if identity is not inextricably tied to tangible tasks or technical specialisms this connection with the practice environment may be less apparent.

#### 10.3.3.2 Conceptualising the values and knowledge-based roles in context

Where task-based roles were outwardly defined and their conceptualisation heavily influenced by the practice context, by contrast, values and knowledge-based roles drew from a more internal focus, and the interaction with the practice environment was conceptually different. Interestingly, values-based roles in the narrative accounts were not conceptualised within the framework of external ethical codes for practice (BASW, 2021; BASW, 2022), reflecting the minimal influence participants ascribed to these in the survey findings. Instead, participants drew upon internal values-based knowledge linked to social work education to inform holistic and person-centred practice. This positioning promoted a

social justice focus and, in line with previous conceptualisations, positioned participants to challenge dominant medical and bureaucratic conceptions of practice (Abendstern et al, 2021; Tucker and Webber, 2021). These challenging stances on practice intersected with the knowledge-based roles that participants presented themselves as holding. Technical specialist knowledge around social care systems did form part of their narrative (Abendstern et al, 2016; Allen et al, 2016), and their use of these corresponded with conceptualisations of multiple professional roles with heightened emphasis on elements relevant to their audience (Sim, 2011). However, the prominence of knowledge-based roles was rooted in the social perspective which informed alternative narratives of practice and informed the challenge to dominant medical hegemonies (Karban, 2017; McCrae et al, 2005). Central to participants role as knowledge specialists was not the technical specialism usually ascribed to professionals (Best and Williams, 2019; Wiles and Vicary, 2019) or the task-based roles pertaining to risk and social control associated with social work (Kendall and Stanley, 2017) but the dominance of an alternative perspective to challenge practice norms and expectations which were rooted in medical or procedural assumptions.

Critically, by comparison to the task-based roles, participants' values and knowledge-based roles were presented in terms which suggested far less organisational influence. In this, they formed the core of an over-arching definition of mental health social work, perhaps explaining the high degree of congruence between Welsh and English participants. This is particularly striking when the similarities between the Welsh and English participants are compared to the incongruence evident between the Welsh and English statutory frameworks. As was previously discussed, it has been suggested that social work within the UK is heavily biased toward its statutory roles, with the state exerting substantial influence on social work practice as a result (Wiles, 2017a; Canavan, 2009). From this stance, it would be expected therefore that the varying legislative structures of Wales and England, underpinned by the conflicting ideologies of the Welsh Labour Government and the UK Conservative Government might be expected to lead to drastic variation in ideas of professional role across both nations (Harrington et al, 2021). However, this would hold true only if those external task-based roles were integral in the formation of mental health social work identity. Participants in this research did talk extensively about their statutory duties, but these were framed in the context of responsibilities to be fulfilled rather than

definitions of purpose. Legislation provided participants with a framework for action, rather than a framework for approach, and so the tasks across the two jurisdictions varied within the statutory agent role. However, the underpinning values informing that practice showed a higher degree of congruence and legislative distinctiveness across the two nations did not translate into role distinctiveness.

A universal approach to social work practice drawing from internally defined concepts of values and knowledge, developed in the context of training delivered to meet with centralised standards (Social Work England, 2021; Social Care Wales, 2021) has the potential to present in a homogenous manner, regardless of the variations in organisational and legislative contexts. This may also suggest why social workers historically have struggled with the ambiguity linked to role extension and role erosion (Crawford et al, 2008; King and Ross, 2004). Practice rooted in values and an ethically informed knowledge base lacks specific tasks and activities which are often favoured from which to 'hang' a professional identity (Trevithick, 2008). In the context of policy landscapes (Welsh Government, 2012; HM Government, 2011) which minimise the specific social work contribution, it is this which leaves mental health social workers vulnerable to the effects of "creeping genericism" (Brown et al, 2000, p. 426).

This conceptualisation of social work professionalism as representing the intersection between values and knowledge is not a new one (Clark, 2009). Wiles (2013) identified knowledge, values and identity as three separate entities that comprised social work, although in the current research, participants did not view these as distinctly separate. Rather they were presented as interwoven; while other professions might value the technical knowledge that social workers can provide, participants in this context prioritised their values-informed knowledge. Central to their conceptions was not an expertise in legislation, although they acknowledged this role, albeit sometimes grudgingly. However, their focus in knowledge sharing was on a social perspective and how this promoted their values-based practice. This reflects closely the findings by Stone et al (2021) who posited a values-driven approach and a socially informed approach as unifying identifiers for mental health social workers that ran across the European context.

The criticisms of values and knowledge alone as the signifiers of social work professional identity have been detailed extensively earlier in this thesis as being insufficiently unique to define a profession (McCrae et al, 2014; Webber, 2013), while the challenges of explicitly defining a professional value base is fraught with difficulty (Buckland, 2016). However, the values and knowledge used by participants to conceptualise roles here were not without boundaries. Despite participant criticisms of social work education as being insufficient to prepare them for mental health practice, their underpinning values-based roles were firmly rooted in the unique intersection of values-based theory which informs social work education (Higgins et al, 2016). The values perspective that participants adopted was broad only in the sense that it took a holistic view; participants were consistently critical of what they saw as unstructured kindness and unfettered caring in fellow professionals. Participants' values and knowledge-based approach was instead theoretically informed and boundaried, even where their theories were tacitly implied rather than explicitly stated (Trevithick, 2008).

Perhaps more critical in the participant accounts, however, was the intersection of all three aspects of professional role. While positions in the literature tend to present task-based approaches and values-based approaches as distinctly separate (Goemans, 2012; Dwyer, 2005), participants in this research positioned them as intrinsically linked. Their values and knowledge-based roles were undertaken within, and rooted within, the practicalities of their substantive practice context; their task-based roles were exclusively filtered through a values and knowledge lens. Participants did not distinguish between the practical roles which were defined by their position within the practice setting, and the theoretical frameworks they used to address these. Instead, values and knowledge frameworks informed the interpretation and undertaking of tasks. Correspondingly, as one participant described it, social work could not be described in black and white terms. Clearly delineated tasks were always contextual, informed by a holistic perspective and a person-centred approach which contrasted against more technically medical health-based tasks.

#### 10.3.3.3 Considering the bigger picture: the relevance of the wider context

Participant accounts of context were not restricted to the organisational setting but similar themes of variation in tasks but consistency in values and knowledge were evident throughout the relational, locational and structural factors that participants discussed. Critically, wider factors fell broadly into two key categories: enactment of the values-based roles and defence of the knowledge-based roles.

Ideas around contextual working, linked to the locational and relational factors, reflected existing positionings of social workers as cross-boundary workers (Oliver, 2013; Nathan and Webber, 2010). Participant accounts of the functional tasks in relation to these were highly context specific, illustrated most clearly by their contrasting experiences in urban and rural settings. However, the intentions underpinning such tasks were universally values-based. How clients were worked with in context was entirely dependent on that context, but the objectives of working in such a holistic fashion were linked to facilitating socially just outcomes which met the needs of the individual as a whole rather than focusing specifically on the mental health diagnosis. Similarly, the significance of practice location and the importance of the office as a working space did not relate to the sense of space as professional domain, but rather to the opportunities such spaces provided to forge connections and build relationships which facilitated the participants' values-based approach to practice. Participants acknowledged the power differential in being the minority perspective in a medically dominated domain (Beddoe, 2017; Beinecke and Huxley, 2009). The inherent risks of being subsumed within medical hierarchies were therefore countered through use of practice locations as a means to foster conditions which would mitigate that dominance.

The corresponding defence of participants professional status was rooted within their interactions with other professionals and their engagement with support and development opportunities. Defence of the social perspective, and by extension the social work position, manifested most clearly in relation to interprofessional conflict, with intransigence in response to external professional misunderstandings reflecting previous literature around defensiveness as a response to poor role articulation (Belling et al, 2011). Webb (2015) positioned social work resistance in such contexts as enhanced, reflecting, again, the disempowered and marginalised position which social work holds within the

multidisciplinary health setting (Beddoe et al, 2017; Nathan and Webber, 2010). This was clearly illustrated in both the boundaried approach that participants took to defending their mental health social worker role. Their rejection of underlying structures around limitations in social work knowledge and deficiencies in organisational support that they perceived as running contrary to their professional positioning or insufficient in maintaining and developing their social perspectives and approach was seen consistently across all contexts. The anticipations that role would become defined by external expectations of how this would be undertaken (Goffman, 1959) were strongly resisted by participants in this research, reflecting Carey's (2014) conceptualisation of social workers' cynical but quiet defiance rather than compliance with conflicting external perspectives.

Indeed, this idea of 'quiet resistance' ran through participants accounts of both their roles and the contextual influences which surrounded them. Despite demonstrating clear concerns about the risks of unwanted external influence dictating the nature of practice (Webb, 2017; Goffman, 1959) participants consistently demonstrated a 'working around' of these influences. While resistance could, and was, demonstrated as open challenge, there was also an element of unspoken adjustment to reduce the impact of external forces. Participants positioned themselves as taking necessary action to protect their professional identity, both passively and actively, in ways which did not draw attention, but which enabled them to safeguard their values and knowledge-based approaches from influences which they saw as undermining or precluding the enactment of these. This reflected a resistance to identity regulation; a sceptical outlook on the mechanics of practice which aim to inform and control how professional identity is enacted. Participants demonstrated an awareness and responded to this, but their approach to subversion was often non-confrontational (Carey, 2014), most frequently manifesting as avoidance or obfuscation. In this, participants used their awareness of context to enable not poor practice, but practice which potentially conflicted with the broader aims of the services and organisations they worked within.

In this context therefore, conceptualising professional roles in mental health social work necessitates an accounting of the practice environment. With task-based roles inextricably linked to the practice context; the tasks that social workers completed on a daily basis were

always filtered through the aims, objectives and practice priorities of the organisation-as-setting, but this did not in principle define the scope of the professional role. In order to consider how this might translate into an accessible and understandable definition of professional role, it is therefore necessary to conceptualise the current interface of mental health social work roles and practice context.

## 10.4 A multi-faceted identity: Conceptualising professional role in mental health social work

The findings discussed here clearly position mental health social work as a complex interplay of individual attributes (Joynes, 2018), shared group identity (Tajfel and Turner, 2004), organisational influence (Evetts, 2013) and wider holistic context. The following model (Figure 10.1) attempts to rationalise this interplay and demonstrate the interactions of the different roles and influencing factors identified in this study:

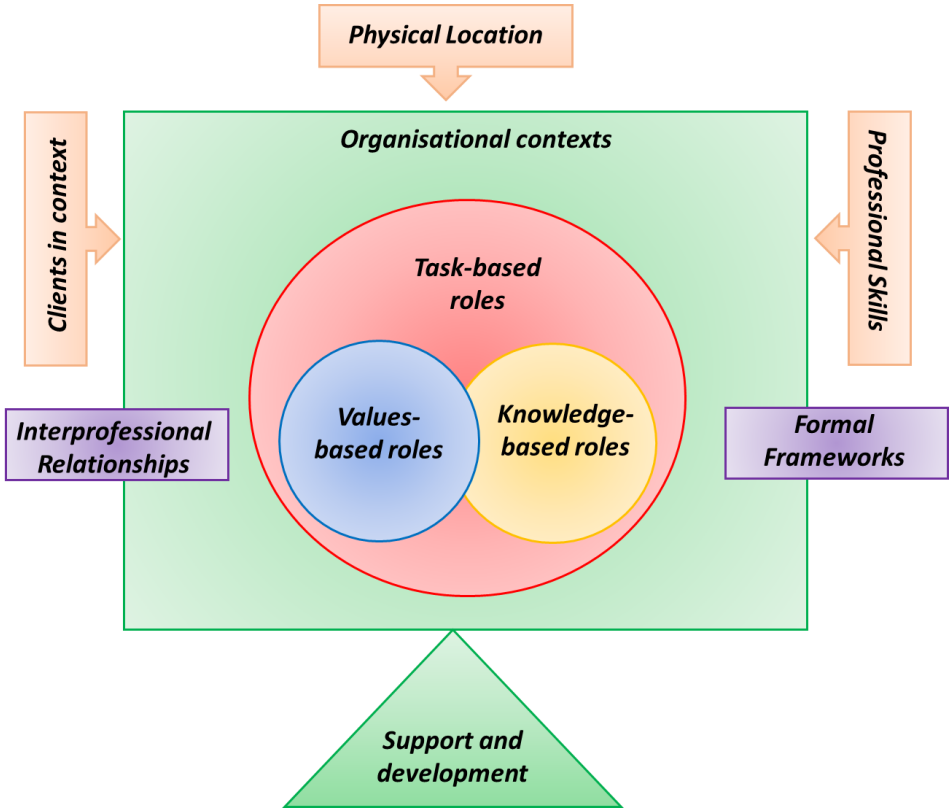



Figure 10.1: A multilevel interactional framework of the mental health social work professional

Positioned at the centre of the framework, the values-based and knowledge-based roles represent the core of mental health social work. As the role positions that held constant in the participant accounts regardless of practice setting or wider contextual factors, they rooted participants' professional practice in a holistic, person-centred framework, which intersected with a socially informed perspective on mental health and was grounded in social justice principles. These two roles drew on participants internal resources and, as such, are guarded from external influence by the wider framework of task-based roles. Centralising and cushioning these values and knowledge-based roles reflects both the participant accounts and the wider conceptualisations of the values-based roots of mental health social work established in previous research (Tucker and Webber, 2021; Abendstern et al, 2021, Norman and Peck, 1999).

These roles are operationalised through the filter of the task-based roles, which intersect with the organisational contexts in every direction. In this sense, it is the task-based roles which adjust and adapt to meet the shifting needs and changing priorities of the organisational context, while the core roles of values and knowledge remain constant. Where knowledge-based and values-based roles interact with the organisation, such as through the Challenge Agent or the Discourse Challenger, this still occurs through the medium of the task-based roles: undertaking the substantive work of assessment and case management, or in the exercise of statutory duties. The task-based roles here encircle the values and knowledge-based roles to reflect how these internally driven approaches are given shape and focus by the externally defined tasks.

Mental health social workers similarly interact with formal frameworks and form interprofessional relationships, both productive and challenging, within the organisational context and in undertaking their organisational roles. How social workers interact with formal frameworks, principally the legislative structure which underpins practice, is informed by the substantive role within which they practice. This reflects the distinction between statutory duties which are the responsibility of the professional and statutory duties which are the responsibility of a public body as enacted by a professional (Tucker and Webber, 2021). Even in the exercise of AMHP duties, working independently of their local authority or NHS trust to undertake a Mental Health Act 1983 assessment, a mental health

social worker would be undertaking that assessment in the context of providing the capacity to do so on behalf of the local authority (Care Quality Commission, 2018). Interprofessional relationships are similarly driven by context, although the multiagency nature of the health, social care and welfare landscape ensures that these relationships are likely to cross organisational boundaries. Relationships are built not through the inherent professional nature of being a social worker, but through the enactment of task-based organisational roles in a substantive employment context.

Feeding into the model from the outside are the wider contextual factors that impact on mental health social work practice: physical location, clients in context and professional skills. While professional skills relate to developments in social work on a national or international scale, the first two – clients in context and physical location – are specific to individual practice contexts. While all mental health social workers will interact with the physical, cultural and societal contexts within which their practice is situated, that experience will be shaped by both their particular location and the organisational aims that underpin their service. Participants in this research described a range of contextual factors linked to population demographics, geographical variation and regional boundaries which influenced their approach to practice from one direction, drawing on their values-based role as a holistic practitioner (Tucker and Webber, 2021). However, this approach was still filtered through an organisational perspective. In this context, participants boundaried their work in line with a power-based approach for professionalisation, drawing on the organisational task-based roles as their basis for limitation (Weiss-Gal and Welbourne, 2008). Perspectives on practice were still informed by holistic and person-centred approaches, but it was frequently within the context of fulfilling the organisational role that participants were able to distinguish the limits of their intervention and feel confident to draw on the authority of the organisation to support this (Saks, 2016) in a way that was not applicable to the internalised values-based roles.

Underpinning this interplay of factors, and inextricably linked to the organisational setting, is an unstable base of professional support and development. The instability of this base reflects participant accounts of supervision and peer support arrangement which ranged from highly supportive and effective to managerial, bureaucratic and unfit for purpose,

reflecting longstanding concerns regarding social work supervision in multidisciplinary settings (Morriss, 2016a; Godden, 2012). Development opportunities were similarly inconsistent and dictated by practice contexts, with NHS-based opportunities more reflective of a mental health specialism to the neglect of social work, while local authority opportunities were more relevant to social work but without consideration of mental health. The extent to which these were relevant for participants linked directly to their personal career aspirations rather than an overall intention of professional development, in clear contradiction to the stated educational and policy aims in health and social care contexts (Health Education England, 2020, Welsh Government, 2020, Wiles, 2017a).

This model takes an integrative stance to defining mental health social work professionalism that is heavily rooted in the particular circumstances of mental health practice. Rather than conceptualising a professional model that draws on attributes (Weiss-Gal and Welbourne, 2008), professionalism is structured around MacAteer et al's (2016) three tier model of successful employment: the professional individual, the professional role and the practice context. In adopting this model, the professional individual is built from the consistent application of values-based and knowledge-based roles which, while applied to a context, tend to influence rather than be influenced by that context. Influences on the values-based and knowledge-based roles manifest in terms of *how* the role is undertaken, rather than *what* is done in any particular circumstance. Professional role in this conceptualisation relates specifically to the task-based, organisation-influenced roles, which interact with the practice context in an integrative manner.

The model builds upon existing categorisations of the mental health social worker, suggesting a degree of consistency in terms of how mental health social workers professionally visualise themselves. Narratives of values-based roles have remained consistent in mental health social worker accounts of their practice for over two decades (Abendstern et al, 2021; Tucker and Webber, 2021; Peck and Norman, 1999), while a similar strong identification with social work as a profession has been equally consistent (Tucker and Webber, 2021; Bailey and Liyanage, 2012). By linking task-based roles as inextricable from context rather than an integral element of professionalism however, the model challenges conventional approaches to defining mental health social work in the sense of

over-arching and context-divorced obligations. This moves away from defined tasks in favour of conceptual categories of task that can be inclusive of contextual variation. This distinction does not necessarily allow for easy implementation but perhaps provides some explanation for why task-based definitions have proven so difficult to embed into practice (Tucker and Webber, 2021).

Indeed, establishing role on the basis of task for mental health social workers (Allen et al, 2016) assumes one core truth in order to be effective: the task-based roles in this setting are fixed. However, the integration of task-based roles with organisational setting renders this assumption invalid. Variation is rife across contexts and across time, providing no core basis on which to formulate a robust professional framework that can be actualised. Best and Williams (2019) posit that professional identity is a collective representation of a group requiring a degree of consensus. In the context of these findings, consensus existed not in the tangible task-based roles that participants undertook, but rather in the framework of knowledge and values which underpinned how these tasks were approached and completed.

The interaction of values and tasks is critical here. Given the challenges historically in defining a vales base for social work (Buckland, 2016) and the subjective nature of knowledge and approaches to practice (Wiles, 2017a), in principle mental health social work has been positioned with a lack of clear role and the inherent threat to identity that this infers (Osburn, 2006). However, while participants spoke with frustration about outsider misunderstandings of their role, in general they spoke confidently about their professional contribution in terms of social perspectives, holistic practice and person-centred approaches. The difficulties in defining the underpinning values were not an aspect of the participant narratives that could be identified throughout the interviews and values were definitively the most influential factor on professional practice for participants more widely in the survey.

This suggests that an inversion of the principle of professional identification might be effective. Rather than defining the profession by its tasks, the model posits that the tasks should be defined by the profession. Boland et al (2019) illustrated the disconnect between

an academic discipline which positioned social work as a values-based profession with a social perspective, represented here by the values and knowledge-based roles, and how mental health social work was experienced by those who make use of services, who saw minimal distinction from nurses. This is perhaps not surprising, however; mental health social worker interactions with their organisations, and by extension, those who access services through those organisations, are primarily task-based. The extent to which values and knowledge can influence is arguably restricted by the scope of the tasks available to the social worker to enact. While these values and perspectives may inform practice, if the scope of practice is limited, then the impact of values and alternative perspectives will be equally limited.

By contrast, situated within principles of social justice, empowerment, respect and promoting a person-centred and holistic approach, mental health social work could be defined not by task-based criteria which will inevitably be exclusionary or inapplicable to a specific practice context, nor by organisational priorities and objectives, considering the professional position of the organisation in light of its managerial, target driven and authoritarian stance (Evetts, 2013). Instead, the mental health social work contribution could be established by identifying where the organisational position and the service priorities fail to address the holistic needs of those accessing mental health services. Effective use of the mental health social work workforce that is driven from a values-based perspective would necessitate an individualised approach to social work practice which, while in line with the stated objectives of mental health policy (Welsh Government, 2012; HM Government, 2011) fit less easily into the medicalised and proceduralised structure of mental health services (Nathan and Webber, 2010). This would in turn require a reconsideration of how mental health social work is delivered, perhaps fittingly in the light of proposed revisions to the Mental Health Act, 1983 (Keen, 2022) which draw on the mental health social workers' core roles to identify the spaces within which they will most effectively operate. Attempts to define the 'social' in the biopsychosocial approach to mental health care can focus on tangible interventions (NHS England, 2021); however, Allen et al's (2016) more conceptual positioning of mental health social work as engaging with communities in diverse and inclusive ways, represents a prioritising of a social justice role aimed at challenging structural inequalities that reinforce mental health difficulties

(Goemans, 2012) and an approach to address specific social circumstance which contribute to poor mental health (HM Government, 2011) may be a more appropriate focus. Morriss' (2016a) conceptualisation of the liminal space may be relevant here, however in this case, the occupation of liminal spaces would be deliberate rather than defaulting. In the same manner as mental health social work developed organically to fill the gaps in how mental health services are provided, it would appear fitting that mental health social workers in turn conceptualise their role to fill the gaps in mental health provision that other professionals cannot meet and that are rooted in the social context of the need experienced, to ensure services are able to meet need in holistic, responsive and adaptable ways.

## 10.5 Strengths and limitations of the research

### 10.5.1 The social work workforce

The workforce survey provides a comprehensive overview of mental health social work provision. With response rates to the survey exceeding 95%, very little data from the whole population was missing from the final count and this negates the need for extrapolation or estimation of the figures to a large degree (O'Connell Davidson and Layder, 1994). This allows for a high level of confidence in understanding the structure of mental health social work with the specific temporal context of the survey, which will in turn allow for future comparisons to track and explore changes or stability in the workforce provision.

The survey was designed to gather the most relevant information in the least intrusive manner possible, acknowledging the high levels of pressure facing public services and the resource demands that such requests for information can pose (Independent Commission on Freedom of Information, 2016; Breathnach et al, 2011). However, due to the brief and remote nature of the survey, there was potential for misinterpretation of the questions which the researcher had no opportunity to clarify. This was specifically a concern in distinguishing AMHPs from the wider mental health social work workforce, acknowledging the distinction between the two roles (Buckland, 2016). To minimise ambiguity, the survey was reviewed within the research team and externally and revised accordingly prior to being

issued and clear definitions of terms were included in advance of the questions; however, the risks of misunderstanding in self-administered surveys cannot be fully removed (Marsh, 1984).

Cross-sectional studies provide a 'snapshot' of a single point in time (Liu, 2008). In the context of a fluid workforce and changing organisational structures, it is noted that the findings from this research will become outdated quickly, as local authority and NHS provision changes; indeed, at the time of writing two local authorities are known to have merged, with one mental health trust in discussion to do similar with a neighbouring trust. As previously highlighted, future research could focus on a more longitudinal understanding, ensuring not only a contemporary view of the workforce, but also an overview of fluctuations over time and how this reflects the broader social and political landscape.

This overview of the structure and provision of mental health social work lacks depth as discussed above; however, preliminary surveys highlight where there is a need for additional work (Bryman, 1988) and the diversity of approach to mental health social work provision which is evident from the results suggests that a more detailed exploration would be beneficial to look at how mental health social work is structured and utilised in these contexts. Furthermore, the lack of correlation between population, need, deprivation and social work provision also suggests that a more detailed exploration to understand the relationship between service provision and local characteristics would be beneficial for future planning and effective use of resources.

### 10.5.2 The social work perspective

The challenge in the unidirectional approach to recruitment undertaken in this research is that non-response to the practitioner survey is difficult to gauge (O'Connell Davidson and Layder, 1994). While the research itself has provided a broad estimate of the size of the target population, and corresponding inferences can be drawn regarding the number of participants, these numbers should be viewed with caution. As previously highlighted, the cross-sectional approach to cataloguing the workforce provided a count for a single moment in time, which in turn may not have reflected the workforce composition at the point of the

survey. Additionally, challenges in establishing where information about the study had been shared, particularly in the context of the coronavirus pandemic, mean it is not possible to draw conclusions around whether engagement with the study reflected disinterest in, unawareness of or lack of capacity for participation. Correspondingly, it becomes difficult to evaluate the extent to which the scope of perspectives captured fully represents mental health social worker perspectives on their own roles; it is possible that, operating within demanding and pressured contexts, those eligible to participate who held less strong views on their role in the mental health context did not prioritise participation. With this in mind, further research which prioritises drawing on a representative rather than a self-selecting range of views would be beneficial to ensure that the picture of mental health social work being developed genuinely represents the practice experience and perspectives of the full professional workforce.

As with the survey of the mental health social work workforce, this survey captured views from a single moment in time (Liu, 2008). Critically, however, the moment in question occurred in the context of an unprecedented moment in modern health and social care delivery. Social research is impacted by social circumstances (Office for National Statistics, 2022) and concerns about the impact of the coronavirus pandemic on the quality of data and generalisability of findings in health and mental health research have been extensively discussed (see, for example, Ramos, 2021; Alsiri et al, 2021; Nieto et al, 2020). In this research, survey distribution took place during the initial coronavirus lockdown in England and Wales, and the impact of this on the social care workforce in terms of heightened distress (Townsend et al, 2020) and social, economic and psychological consequences (House of Commons Health and Social Care Committee, 2020) is impossible to measure. Correspondingly, the impact for the research and the subsequent findings is equally challenging to quantify. To attempt to mitigate against this, participant discussion at the interview stage were rooted in both current and pre-pandemic practice, but the survey findings should nonetheless be considered in the context of the temporal and social context in which they were gathered.

## 10.6 Implications for future research

Participants within this research clearly drew links between the values-base that underpinned their approach to practice and their professional education as social workers. However, the exact nature of these links were rarely clearly articulated, reflecting the challenges inherent in clearly defining the nature of social work values (Buckland, 2016). Given the centrality of values-based practice identified in this research, further exploration of how mental health social workers conceptualise and articulate the link between practice reality and academic theory would be useful in considering how to actualise this link into an effective role description that could be used to inform how mental health social work is enacted within the practice environment.

Health provision in the UK is heavily outcome driven (NHS England, 2014). While this research sought to understand how mental health social work is conceptualised and enacted within practice contexts, it did not consider the effectiveness of this by comparison to other approaches to mental health care. Participants in this research saw clear benefit to their social approaches and social and holistic perspectives form a core narrative of mental health policy, but the outcomes of adopting a social work-led rather than a health-led approach to statutory mental health provision are less clearly established. Future studies could consider these impacts, again with a view to informing how this workforce might be used effectively within wider mental health provision.

Largely absent from the findings of this study were the voices of mental health social workers who delivered statutory services outside of the remit of statutory organisations. The small numbers of participants from these settings made extrapolating from their experiences challenging; however, their accounts, particularly in relation to the organisational setting, suggested a degree of difference from the experiences of those working within statutory contexts, particularly in terms of working effectively with rather than despite the organisation. In the context of considering the future direction of mental health services, and mental health social work more specifically, and acknowledging the criticality of the practice environment in understanding how professional roles are undertaken, a more focused exploration of mental health work in these contexts would provide useful insights into considering how mental health services for the future could or

should be structured, and how these alternative provisions might impact on the workforce and the services they provide.

## 10.7 Implications for policy and practice

This research has implications both in terms of the overall provision of mental health social work, and in the understanding and effective implementation of the role itself. In terms of service provision, development of the mental health workforce across the health and social care spectrum is currently under governmental scrutiny (NHS Benchmarking, 2020; Health Education England, 2020; Welsh Government, 2020); however, understanding of the contribution of those professions who primarily exist external to health settings is limited (Health Education England, 2017). In the context of increasing demand and limited resource even discounting the additional impact of global events (Farnsworth, 2021), a comprehensive understanding of mental health social work provision as it is currently deployed will be useful to policymakers to understand the structure of the current practice context for future effective service planning. This study complements existing data gathering mechanisms within the NHS, providing a corresponding accounting of social work input into the multidisciplinary mental health environment and suggests a prospective value in monitoring of the social care workforce to match that undertaken within the NHS (NHS Digital, 2022). This in turn can be used to support the development of a more comprehensive strategy for how mental health services can be structured effectively and efficiently, ensuring optimum use of the full range of professional expertise available. The localised nature of provision has resulted in a shrouded understanding of the position social work occupies within mental health service delivery. By adopting a national perspective, this study has illuminated the current structure, with a view to contributing toward more cohesive, national plans and setting a reliable benchmark against which further developments can be measured.

Effective service planning cannot be based on numbers alone, and this research raises questions about the current use of the mental health social work workforce and the applicability of existing frameworks for practice (BASW, 2021; Allen et al, 2016). Conceptual frameworks which exist in isolation from frontline actuality (Boland et al, 2019) minimise

the extent to which social work can be deployed effectively in the multidisciplinary environment to complement the contribution of the health professionals it works alongside. The positioning of task-based, values-based and knowledge-based roles as entwined and inseparable, combined with the inherent interaction of the specific practice context and the task-based roles, suggests that there is a need to develop a clearer articulation of the core theoretical ideas underpinning the practice realities of holism, person-centred practice and social justice. While these terms have proven difficult to define in academic contexts (O'Brien, 2010), given how participants in this study spoke about these in distinct terms, a useful approach may be to define these not academically but using these practice terms. Task-based roles have the potential to be generic across practitioners, especially in the context of over-arching policies which promote individual capabilities over professional contributions (HM Government, 2011). However, mental health services continue to be constructed using a diverse range of professional inputs and, in the context of social work as highlighted in this study, those professionals hold strong ideas of professional role that do not necessarily correlate to service expectations. Attempts to enforce external definitions of role are more likely to encounter resistance than compliance (Hannigan and Allen, 2011) and therefore, if social work is to continue to play a role in the provision of mental health services, this role should be conceptualised in the context of social work's distinct contribution. This research has highlighted that commonality in mental health social work lies not in what social workers do, but in the processes which underpin how they do it. Central to the mental health social work role is a knowledge based rooted in social perspectives and undertaken from a position which promotes social justice, person-centred approaches and holistic considerations. Task-based operational roles should therefore be developed with this underpinning framework for application in mind. This would enable service planners to make optimal use of mental health social work's socially informed view on mental health to complement rather than contradict existing medical approaches and enable an explicit focus on addressing the social determinants of mental health.

# Conclusion

Mental health social workers account for a substantial minority of the wider mental health workforce and a similarly substantial minority of the social work workforce (NHS Digital, 2022; Skills for Care, 2022; Social Care Wales & Health Education and Improvement Wales, 2020). However, understanding of the role that social work plays within this wider service structure has historically been challenging, both due to a lack of overview of the nature and extent of mental health social work provision (Anderson et al, 2021) and the absence of agreement around the contribution of social work to this practice environment.

Difficulties in defining the mental health social work role are evident on multiple fronts. The organic and unplanned development of this sub-specialism of social work (Burnham, 2011) has led to a diverse range of working arrangements which do not demonstrate an overarching plan for social work intervention (Evans et al, 2012; Burns and Lloyd, 2004; Mistral and Vellerman, 1997). Legislative and policy initiatives have neglected to fill this gap, illustrating a lack of consensus on the intended role of social work or, indeed, the wider relevance of professional specialism (Health Education England, 2017; Allen et al, 2016; Welsh Government, 2012; HM Government, 2011). Practitioners (Ekeland and Myklbust, 2021) and academics have demonstrated similarly conflicting perspectives on the mental health social work role, resulting in a manifestation as a nebulous, semi-profession, lacking both direction and professional autonomy (Weiss-Gal and Welbourne, 2008) and yet, nonetheless, possessing a strong sense of professional identity (Tucker and Webber, 2021).

Compounding this lack of clarity on professional role is a limited awareness of the nature of the impact of practice context, particularly relevant to mental health social work given the diverse range of practice contexts it operates across (Lilo, 2016). Theoretical and empirical conceptions have frequently posited a connection between professional identity and external influence (Rasmussen et al, 2018; McCrae et al, 2014; Ashforth et al, 2008; McCrae et al, 2007) but the extent and variation in that influence in differing mental health social work contexts had not been fully explored. Attempts to define this role have nonetheless been enacted (Allen et al, 2016) but without a specific consideration of this practice

environment have received minimal engagement from frontline practitioners (Tucker and Webber, 2021).

In considering both a practice-led definition of role that might have universal application, and the extent to which practice context impacted on this, this research established two key ideas which help to contribute to understanding the role of social work in mental health services. Firstly, the lack of consensus within policy and academia about the role of social work in mental health settings was not replicated in this research. Participants adopted an inclusive perspective on their roles which did not position values, knowledge, or tasks as being definitionally contradictory. Instead, all roles were intrinsically linked, with values and knowledge frameworks informing interpretation of, approach to and undertaking of tasks. As such, mental health social work became highly contextual in enactment, but highly consistent in the mode of implementation. What participants did in practice was highly variable, but the manner in which they approached these tasks was consistently underpinned by the same approach and intentions regardless of these variations.

Current theoretical perspectives suggesting that the practice environment is directly influential on professional role and identity did not reflect the extent of the relationship between the two identified in this research. The findings here suggest that divorcing role from practice context is impossible, unless role is to also be divorced from the daily enactment of tasks and responsibilities. This would move professional role away from an attributes-based definition, as outlined by Weiss-Gal and Welbourne (2008) but, critically, would also move role away from the participant-led definitions identified here. For participants in this study, what social workers did – their tasks and responsibilities - was an important aspect of who they were. However, it was only a single aspect within a framework of drivers for their professional identities. While it was the element of identity which was defined situationally rather than by drawing on internal attributes (Ashforth et al, 2008) and ostensibly the most clearly delineated and by extension the easiest to classify, it was not the defining characteristic.

In this, the research captured a fundamental debate in defining mental health social work on a universal scale. The external-facing and outwardly defined task-based roles which

were most straightforward to categorise fit best with official definitions of mental health social work but were also highly variable. Instead, it was the internally defined values and knowledge-based roles which were more consistent with participants in all contexts and which could be applied universally across a range of practice settings. In this conceptualisation, mental health social work as a profession is not defined by the practice-as-setting, but rather everything it does is filtered through that context. As the external visible aspects of the role are also those most closely influenced by the environment, what is seen and understood as mental health social work therefore becomes difficult to clearly define in a universal manner because it is being viewed through the lens of any given organisation. It is perhaps not surprising, therefore, that the mental health social work role becomes impenetrable to understand for professionals viewing it externally (Peck and Norman, 1999) and definitions of the role fall short of universal applicability (Tucker and Webber, 2021).

This research has built upon existing understandings of professional roles in social work and the interaction of the professional and the practice environment to articulate how these can be interpreted for mental health social work. It has established an inextricable link between context and professional identity but has also demonstrated the need for definitions of mental health social work to expand beyond the mechanics of practice if they are to be meaningful and useful in understanding the professional contribution. Despite an awareness of their potential disempowerment (Beddoe, 2017), the unwillingness of participants in this research to surrender to the medical hegemony of mental health services was apparent. Challenge, rather than compromise, remained a driver for practice that was in congruence with the values and knowledge that underpinned it, while narratives that minimised the importance of social work tasks (Morriss, 2016a) were robustly defended against. This adherence to a sense of professional identity which is poorly articulated in policy should be given careful consideration in light of current efforts to reimagine the approach to the delivery of mental health services (Welsh Government, 2020; NHS England, 2019a). The prospective disconnect between policy conceptions and lived realities seems unlikely to result in compliance from frontline practitioners. To make effective use of the mental health social work workforce, a reimagining of the mental health social worker role and contribution is needed that reflects the experience of those who undertake it.

# Appendices

## Appendix 1: Request for information - Mental health social work workforce (Local Authority)

c/o Professor Martin Webber
Department of Social Policy and Social Work
The University of York
Heslington
York
YO10 5FF
Tel: 07902 918101
Email: spsw-mhsw-provider-survey@york.ac.uk

27th February 2019

**Request for information - Mental health social work workforce**

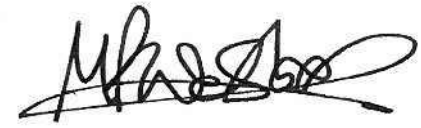
As part of a wider research project looking at the role of social work in mental health services, we are attempting to comprehensively map the provision of mental health social work across England and Wales in order to understand variation and similarity in how this is delivered across different areas. The information is being requested for the initial phases of a PhD research programme.

To ensure we are able to create a complete picture, requests for this information have been sent to all public authorities responsible for the provision of mental health social work.

If your organisation would like to receive a copy of the final report detailing the national provision of mental health social work, please include contact details for the relevant person or team with your response.

Please provide the information detailed in the following questions either electronically or in hard copy to the contact details listed above. If you have any questions or need to discuss this request, please contact Laura Tucker (PhD researcher) on spsw-mhsw-provider-survey@york.ac.uk

Many thanks in advance for your help with this.



Professor Martin Webber
Associate Deputy Head of Department
Director, International Centre for Mental Health Social Research
Senior Fellow, NIHR School for Social Care Research

Laura Tucker
PhD Researcher

**Definitions**

For the purposes of this request for information, the following definitions should be applied:

*Social worker* - Employee in a post requiring a professional qualification where that qualification is recorded as social worker OR employee in a non-qualified post who holds a professional qualification recorded as social worker

*Mental health provision* - A service or role where service user eligibility is based upon mental health need

1. How many social workers employed directly by the Local Authority work within mental health provision?

2. Does the number above include the Approved Mental Health Professional workforce? If yes, how many social work Approved Mental Health Professionals are employed by the local authority?

3. Are the mental health social workers employed directly by the local authority (please indicate all which apply):

☐ Based in local authority teams

☐ Based in NHS teams under direct local authority line management

☐ Based in NHS teams without direct local authority line management

4. What formal or informal arrangements does the local authority have with local NHS providers for the provision of mental health services (please describe)?

5. Does the local authority commission any mental health social work provision from a third party provider? If yes, which services are externally commissioned?

Date information compiled:

Contact details for final report:

## Appendix 2: Request for information - Mental health social work workforce (NHS Trust)

c/o Professor Martin Webber
Department of Social Policy and Social Work
The University of York
Heslington
York
YO10 5FF
Tel: 07902 918101
Email: spsw-mhsw-provider-survey@york.ac.uk

27th February 2019

**Request for information - Mental health social work workforce**

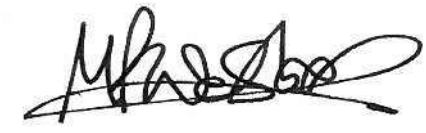
As part of a wider research project looking at the role of social work in mental health services, we are attempting to comprehensively map the provision of mental health social work across England and Wales in order to understand variation and similarity in how this is delivered across different areas. The information is being requested for the initial phases of a PhD research programme.

To ensure we are able to create a complete picture, requests for this information have been sent to all public authorities responsible for the provision of mental health social work.

If your organisation would like to receive a copy of the final report detailing the national provision of mental health social work, please include contact details for the relevant person or team with your response.

Please provide the information detailed in the following questions either electronically or in hard copy to the contact details listed above. If you have any questions or need to discuss this request, please contact Laura Tucker (PhD researcher) on spsw-mhsw-provider-survey@york.ac.uk

Many thanks in advance for your help with this.



Professor Martin Webber
Associate Deputy Head of Department
Director, International Centre for Mental Health Social Research
Senior Fellow, NIHR School for Social Care Research

Laura Tucker
PhD Researcher

**Definitions**

For the purposes of this request, the following definitions should be applied:

*Social worker* - Employee in a post requiring a professional qualification where that qualification is recorded as social worker OR employee in a non-qualified post who holds a professional qualification recorded as social worker

*Mental health provision* - A service or role where service user eligibility is based upon mental health need

1. Does the NHS trust directly employ any social workers to work within mental health provision? If yes, how many? If no, please proceed to question 4

| |
|---|
| |

2. Does the number above include any Approved Mental Health Professionals? If yes, how many social work Approved Mental Health Professionals are employed by the NHS trust?

| |
|---|
| |

3. In which of the following service areas does the trust directly employ mental health social workers (please provide numbers for each area or, if unable to do so, please provide a total figure in the 'other' box):

| | |
|---|---|
| | CAMHS |
| | Early Intervention in Psychosis |
| | Working Age Adults |
| | Older Adults |
| | Forensic Mental Health |
| | Inpatient services |
| | Crisis Resolution and Home Treatment |
| | Other (please specify): |

4. Are any mental health services provided by the trust commissioned from a third party provider? If yes, which services are externally commissioned?

| |
|---|
| |

Date information compiled:

Contact details for final report:

## Appendix 3: Request for information - Mental health social work workforce (Local Health Board)

c/o Professor Martin Webber
Department of Social Policy and Social Work
The University of York
Heslington
York
YO10 5FF
Tel: 07902 918101
Email: spsw-mhsw-provider-survey@york.ac.uk

27th February 2019

**Request for information - Mental health social work workforce**

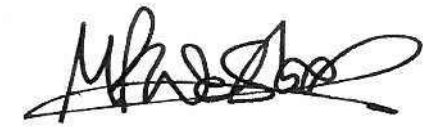
As part of a wider research project looking at the role of social work in mental health services, we are attempting to comprehensively map the provision of mental health social work across England and Wales in order to understand variation and similarity in how this is delivered across different areas. The information is being requested for the initial phases of a PhD research programme.

To ensure we are able to create a complete picture, requests for this information have been sent to all public authorities responsible for the provision of mental health social work.

If your organisation would like to receive a copy of the final report detailing the national provision of mental health social work, please include contact details for the relevant person or team with your response.

Please provide the information detailed in the following questions either electronically or in hard copy to the contact details listed above. If you have any questions or need to discuss this request, please contact Laura Tucker (PhD researcher) on spsw-mhsw-provider-survey@york.ac.uk

Many thanks in advance for your help with this.



Professor Martin Webber
Associate Deputy Head of Department
Director, International Centre for Mental Health Social Research
Senior Fellow, NIHR School for Social Care Research

Laura Tucker
PhD Researcher

**Definitions**

For the purposes of this request, the following definitions should be applied:

*Social worker* - Employee in a post requiring a professional qualification where that qualification is recorded as social worker OR employee in a non-qualified post who holds a professional qualification recorded as social worker

*Mental health provision* - A service or role where service user eligibility is based upon mental health need

1. Does the Local Health Board directly employ any social workers to work within mental health provision? If yes, how many? If no, please proceed to question 4

| |
|---|
| |

2. Does the number above include any Approved Mental Health Professionals? If yes, how many social work Approved Mental Health Professionals are employed by the Local Health Board?

| |
|---|
| |

3. In which of the following service areas does the Local Health Board directly employ mental health social workers (please provide numbers for each area or, if unable to do so, please provide a total figure in the 'other' box):

| | |
|---|---|
| | CAMHS |
| | Early Intervention in Psychosis |
| | Working Age Adults |
| | Older Adults |
| | Forensic Mental Health |
| | Inpatient services |
| | Crisis Resolution and Home Treatment |
| | Other (please specify): |

4. Are any mental health services provided by the Local Health Board commissioned from a third party provider? If yes, which services are externally commissioned?

| |
|---|
| |

Date information compiled:

Contact details for final report:

Appendix 4: Participant Information Sheet (social worker survey)

# Unweaving the web: Using a mixed methods approach to understand the role and contribution of mental health social work to the delivery of mental health services in England and Wales.

**Participant Information Sheet**

Thank you for considering taking part in this research study about social work in mental health services. This information sheet is provided in order to answer any questions you might have about the study; if you want to know anything not covered here, please do contact the PhD researcher on the contact details below

**Who is undertaking the study?**

This study is being undertaken by Laura Tucker at the University of York as part of a PhD in Social Work

**What is the purpose of the study?**

Social work has a long history in mental health services, but how these services are structured has developed without a clear understanding of the contribution that social work is intended to make. Services are organised in very different ways across the country and, while some work has been done in recent years to identify key aspects of the social work role in mental health, previous research undertaken by this researcher suggests that this may not have translated easily into the varied circumstances of frontline practice.

This study aims to explore how social workers working primarily in mental health view their professional role, and how working in different parts of the country within different teams and organisations might affect these roles.

**Why have I been invited to take part?**

The initial survey aims to capture the views of mental health social workers working in as many different environments as possible. You are invited to take part if you are a qualified or registered social worker in England or Wales working primarily in mental health. You do not need to be in a social work specific role, as long as a substantial portion of your clients (or the clients supported by your team in the case of social work managers) are accessing help on the basis of their mental health

**What does taking part involve?**

You will be provided with a link to an online survey to complete at a time suitable to you. This survey will collect some general information about you and your role in mental health. You will then be asked questions about your views on social work professional identity, and about your experience of working in your current setting. The questions all involve using rating scales and you will not be asked to enter detailed answers. At the end of the survey you will be given the opportunity to volunteer to take part in follow up interviews and asked to provide a contact email address for this purpose.

This is a single survey which should take around 15 minutes to complete. You will not be asked to provide any more information, unless you wish to take part in the interview stage of the study.

All information will be provided anonymously. If you volunteer for the interview stage of the study, you will be asked to provide you email address alongside the general information about you (to help with selecting a good representation of participants for the interviews) but this will be kept separately to your answers to the rest of the questions. It may be that you are not selected to take part in interviews even if you volunteer and, in this case, your contact information will be deleted immediately.

**Do I have to take part?**

No – participation is entirely voluntary and you can stop the survey at any time. You can also opt out of interviews at a later date even if you provide contact information now.

**Will I be identified in any research outputs?**

As the survey is completed anonymously and does not involve any written answers, it will not be possible to identify you in any research output. Reports and presentations on the findings from this survey will include overall trends and themes from the whole group of participants.

**How will you keep my data secure?**

The survey is administered using one of the University of York survey tools, and all data submitted is securely sent to the university servers. Responses will be maintained on these secure servers and accessed via password protected devices.

**For how long will you keep my data?**

Any personal identifying data will be destroyed at the end of the programme of study (by September 2022 at the latest). Anonymised datasets will be kept for ten years.

**Will you share my information with anyone else?**

Any personal information you share (such as email addresses) will not be shared with anyone other than the PhD researcher. At the end of the study, anonymised data will be made available for other researchers to use but will not be possible to identify you from this data. For more information on your data protection, please see the data information sheet.

**Who has given approval to conduct the research?**

Ethical approval has been granted by the University of York. Governance oversight has been granted by the Health Research Authority.

**How do I find out more information?**

Student Researcher: **Laura Tucker**
Email: **laura.tucker@york.ac.uk**

**How do I make a complaint?**

In the first instance, please contact the academic supervisor for this study:

Academic Supervisor: **Professor Martin Webber**
Email: **martin.webber@york.ac.uk**

If you are not satisfied that your complaint has been resolved at this stage, please contact the Departmental Ethics Committee using the email address: **spsw-ethics@york.ac.uk.**

**Data Information Sheet**

**Unweaving the web: Using a mixed methods approach to understand the role and contribution of mental health social work to the delivery of mental health services in England and Wales.**

The purpose of this information sheet is to explain how your data will be used and protected, in line with GDPR.

**On what basis will you process my data?**

Under the General Data Protection Regulation (GDPR), the University must identify a legal basis for processing personal data and, where appropriate, an additional condition for processing special category data.

In line with our charter which states that we advance learning and knowledge by teaching and research, the University processes personal data for research purposes under Article 6 (1) (e) of the GDPR:

*Processing is necessary for the performance of a task carried out in the public interest*

Special category data is processed under Article 9 (2) (j):

*Processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes*

Research will only be undertaken where ethical approval has been obtained, where there is a clear public interest and where appropriate safeguards have been put in place to protect data.

In line with ethical expectations and to comply with common law duty of confidentiality, we will seek your consent to participate where appropriate. This consent will not, however, be our legal basis for processing your data under the GDPR.

**How will you use my data?**

Data will be processed for the purposes outlined in this notice and in the main information sheet. All survey data will be collected anonymously through a secure online data collection tool. You will be required to provide informed consent for participation before being asked to answer any questions. The anonymised findings will be analysed and a research paper submitted to the University and to a journal with the aim of publication. A summary of the findings will also be made available to local authorities and NHS trusts and a copy of this can be provided to you on request. You will not receive this automatically as the researcher will not be holding your contact information

**How will you keep my data secure?**

The University will put in place appropriate technical and organisational measures to protect your personal data and/or special category data. For the purposes of this project we will ensure that all survey responses are password protected and saved onto the secure University of York fileserver.

Information will be treated confidentiality and shared on a need-to-know basis only. The University is committed to the principle of data protection by design and default and will collect the minimum amount of data necessary for the project.

**Will you share my data with 3rd parties?**

Anonymised data will only be accessible to Laura Tucker (University of York) and the two academic supervisors for this study while the research is ongoing. We will request that other researchers have access to the anonymised dataset for future research following completion of this study.

**Will I be identified in any research outputs?**

You will not be identified in any research output.

**How long will you keep my data?**

Data will be retained in line with legal requirements or where there is a business need. Retention timeframes will be determined in line with the University's Records Retention Schedule. Anonymised datasets will be retained for three years from the end of the study.

**What rights do I have in relation to my data?**

Under the GDPR, you have a general right of access to your data, a right to rectification, erasure, restriction, objection or portability. You also have a right to withdrawal. Please note, not all rights apply where data is processed purely for research purposes. For further information see, https://www.york.ac.uk/records-management/generaldataprotectionregulation/individualsrights/.

For this particular study, because data is submitted anonymously, it will not be possible to withdraw your responses once they have been submitted.

**Questions**

If you have any questions about this participant information sheet or concerns about how your data is being processed, please contact martin.webber@york.ac.uk. If you are still dissatisfied, please contact the University's Acting Data Protection Officer at dataprotection@york.ac.uk.

If you are unhappy with the way in which the University has handled your personal data, you have a right to complain to the Information Commissioner's Office. For information on reporting a concern to the Information Commissioner's Office, see www.ico.org.uk/concerns.

Appendix 5: Consent form (social worker survey)

## CONSENT FORM

**Unweaving the web: Using a mixed methods approach to understand the role and contribution of mental health social work to the delivery of mental health services in England and Wales.**

Please read the following statements relating to this research before you start. If you are happy to take part in the research on this basis, please tick the boxes to confirm this. You will then be able to move on to the survey. If you'd like to discuss any of these areas in more detail before completing the survey, please email laura.tucker@york.ac.uk

| | **Please tick box to agree** |
|---|---|
| I have been told what this research is about and what it involves. I have been given an information sheet [dated ../../..] and have had opportunity to ask questions. | |
| I understand that I do not have to take part in the research. I am free to withdraw at any time without giving a reason and without affecting my employment | |
| I understand that I will not be named in any research reports, and my personal information will remain confidential. | |
| I understand that I will not be able to amend or withdraw information I provide once my survey has been submitted | |
| I agree for my anonymous data to be archived at the University of York, and to be made available for use by other researchers | |
| I agree to take part in the research | |

*Explanatory note: Due to the online nature of the survey, signed consent will not be secured; however, participants will need to acknowledge their agreement to this consent form in order to be able to complete the full survey.*

## Appendix 6: Social Worker Survey

**Social Worker Survey**

***Initial Demographics***

*This section asks some general questions about you, and about your experience as a mental health social worker, so that we can understand how representative our respondents are of the wider social worker workforce*

1. What is your age?

   | |
   |---|
   | |

2. What best describes your gender?

   ☐ Male

   ☐ Female

   ☐ Prefer not to say

   ☐ Prefer to self describe

3. What is your ethnic group (please choose the group that best describes your ethnic group or background)?

   **White**
   1. English/Welsh/Scottish/Northern Irish/British
   2. Irish
   3. Gypsy or Irish Traveller
   4. Any other White background, please describe

   **Mixed/Multiple ethnic groups**
   5. White and Black Caribbean
   6. White and Black African
   7. White and Asian
   8. Any other Mixed/Multiple ethnic background, please describe

   **Asian/Asian British**
   9. Indian
   10. Pakistani
   11. Bangladeshi
   12. Chinese
   13. Any other Asian background, please describe

   **Black/ African/Caribbean/Black British**
   14. African
   15. Caribbean
   16. Any other Black/African/Caribbean background, please describe

   **Other ethnic group**

17. Arab
18. Any other ethnic group, please describe

4. How long have you been qualified as a social worker in the UK (excluding any time spent registered as a student)?

   ☐ Less than 6 months

   ☐ 6 months-2 years

   ☐ 2-5 years

   ☐ 6-10 years

   ☐ 11-20 years

   ☐ More than 20 years

5. How long have you worked in mental health (whether as a social worker or in other roles)?

   ☐ Less than 6 months

   ☐ 6 months-2 years

   ☐ 2-5 years

   ☐ 6-10 years

   ☐ 11-20 years

   ☐ More than 20 years

6. What type of organisation are you currently employed by?

   ☐ NHS Trust

   ☐ Local Authority

   ☐ Private sector organisation

   ☐ Third sector organisation

   ☐ Other (please specify): _____

7. Where are you normally based for your day to day work?

   ☐ In an NHS-managed team at an NHS base

   ☐ In a Local Authority-managed team at an NHS base

   ☐ In a Local Authority-managed team at a Local Authority base

☐ In an NHS-managed team at a Local Authority base

☐ In a Private Sector team

☐ In a Third Sector team

☐ Other (please specify): _____

8. How long have you worked in your current team?

| |
|---|
| |

9. Which of these working environments do you have experience of working in (tick all that apply)?

☐ In an NHS-managed team at an NHS base

☐ In a Local Authority-managed team at an NHS base

☐ In a Local Authority-managed team at a Local Authority base

☐ In an NHS-managed team at a Local Authority base

☐ In a Private Sector team

☐ In a Third Sector team

☐ Other (please specify): _____

***Social work identity***

*This section explores your views on your professional identity as a mental health social worker*

*SISI (adapted from Postmes et al, 2013)*

**Rank the following statements based on how closely they describe how you feel about your professional identity, where 1 is a poor description and 7 is a strong description**

I identify with social workers ☐1 ☐ 2 ☐ 3 ☐ 4 ☐5 ☐ 6 ☐ 7

I identity with mental health workers ☐1 ☐ 2 ☐ 3 ☐ 4 ☐5 ☐ 6 ☐ 7

I identify with mental health social workers ☐1 ☐ 2 ☐ 3 ☐ 4 ☐5 ☐ 6 ☐ 7

*Social work identity*

**How important is your professional identity to you, where 1 is not important at all and 7 is very important**

☐1 ☐ 2 ☐ 3 ☐ 4 ☐5 ☐ 6 ☐ 7

**Rank these factors in terms of how they influence your professional identity. Place the most influential first and the least influential last.**

| |
|---|
| Your social work education and training |
| The nature or requirements of your work role |
| Using social work specific skills in practice |
| Being part of a team with social work colleagues |
| Working with distinctive social work theories and interventions |
| Working within a social work values base |
| Belonging to a professional organisation |
| Working to professional standards of conduct |
| The ethos of the organisation you work in |
| Working to a professional code of ethics |
| Public perceptions of social work |

**In your opinion, is professional identity different to personal identity?**

☐ Very much ☐ Some ☐ A Little ☐ Not at all ☐ I'm not sure

***The practice environment***

*This section explores the culture and working environment in your current workplace*

*PES-NWI (adapted from Lake, 2002)*

**For each item, please indicate the extent to which you agree that the item is PRESENT IN YOUR CURRENT JOB.**

| | |
|---|---|
| Adequate support services allow me to spend time with my service users. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Medical staff and social workers have good working relationships. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Supervisors are supportive of the social workers. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Active staff development or continuing education programs for social workers. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |

| | |
|---|---|
| Opportunities for social work specific career and skills development | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Opportunity for social workers to participate in policy decisions. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Supervisors use mistakes as learning opportunities, not criticism. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Enough time and opportunity to discuss service users issues with other social workers. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Enough qualified social workers to provide quality care | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| A manager who is a good manager and leader. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| A lead social worker who is highly visible and accessible to staff. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Enough staff to get the work done. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Praise and recognition for a job well done. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| High standards of social work are expected by the organisation. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| A lead social worker equal in power and authority to other decision-makers within the organisation | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| A lot of teamwork between social workers and medical staff | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Opportunities for advancement. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| A clear philosophy of social work that pervades the care environment. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Working with social workers who are professionally competent. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| A manager who backs up the social workers in decision-making, even if the conflict is with a doctor | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |

| | |
|---|---|
| An organisation that listens and responds to employee concerns. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| An active quality assurance programme. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Social workers are involved in the internal governance of the department (e.g., practice and policy committees). | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Collaboration (joint practice) between social workers and medical staff. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| A mentorship programme for newly hired social workers. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Social work intervention is based on a social, rather than a medical, model. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Social workers have the opportunity to get involved with internal organisation committees | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| An organisation which consults with staff on daily problems and procedures. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Written, up-to-date care plans for all service users which include a social work element. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Case allocations that foster continuity of care, i.e., the same team member works with the service user from one contact to the next. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Use of social work models for care planning and intervention. | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |

*Culture of Care Barometer (adapted from Rafferty et al, 2015)*

**Thinking about your current workplace, to what extent do you agree with the following statements:**

| | |
|---|---|
| I have all the resources I need to do a good job | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| I feel respected by my co-workers | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| I have sufficient time to do my job well | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |

| | |
|---|---|
| I am proud to work in this organisation | ☐ Strongly Agree ☐ Agree ☐ No opinion<br>☐ Disagree ☐ Strongly Disagree |
| My line manager treats me with respect | ☐ Strongly Agree ☐ Agree ☐ No opinion<br>☐ Disagree ☐ Strongly Disagree |
| My organisation values the service we provide | ☐ Strongly Agree ☐ Agree ☐ No opinion<br>☐ Disagree ☐ Strongly Disagree |
| I would recommend this organisation as a good place to work | ☐ Strongly Agree ☐ Agree ☐ No opinion<br>☐ Disagree ☐ Strongly Disagree |
| I feel well supported by my line manager | ☐ Strongly Agree ☐ Agree ☐ No opinion<br>☐ Disagree ☐ Strongly Disagree |
| I am able to influence the way things are done in my team | ☐ Strongly Agree ☐ Agree ☐ No opinion<br>☐ Disagree ☐ Strongly Disagree |
| I feel part of a well managed team | ☐ Strongly Agree ☐ Agree ☐ No opinion<br>☐ Disagree ☐ Strongly Disagree |
| I know who my line manager is | ☐ Strongly Agree ☐ Agree ☐ No opinion<br>☐ Disagree ☐ Strongly Disagree |
| Unacceptable behaviour is consistently tackled | ☐ Strongly Agree ☐ Agree ☐ No opinion<br>☐ Disagree ☐ Strongly Disagree |
| There is strong leadership in the highest levels of the organisation | ☐ Strongly Agree ☐ Agree ☐ No opinion<br>☐ Disagree ☐ Strongly Disagree |
| When things get difficult, I can rely on my colleagues | ☐ Strongly Agree ☐ Agree ☐ No opinion<br>☐ Disagree ☐ Strongly Disagree |
| Managers in the organisation know how things really are | ☐ Strongly Agree ☐ Agree ☐ No opinion<br>☐ Disagree ☐ Strongly Disagree |
| I feel able to ask for help when I need it | ☐ Strongly Agree ☐ Agree ☐ No opinion<br>☐ Disagree ☐ Strongly Disagree |
| I know exactly what is expected of me in my job | ☐ Strongly Agree ☐ Agree ☐ No opinion<br>☐ Disagree ☐ Strongly Disagree |
| I feel supported to develop my potential | ☐ Strongly Agree ☐ Agree ☐ No opinion<br>☐ Disagree ☐ Strongly Disagree |
| A positive culture is visible where I work | ☐ Strongly Agree ☐ Agree ☐ No opinion<br>☐ Disagree ☐ Strongly Disagree |

| | |
|---|---|
| The people I work with are friendly | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| My line manager gives me constructive feedback | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| Staff successes are celebrated by my organisation | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| The organisation listens to staff views | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| I get the training and development I need | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| I am able to influence how things are done in my organisation | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| The organisation has a positive culture | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| I am kept well-informed about what is going on in our team | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| I have positive role models where I work | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| I feel well informed about what is happening in the organisation | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |
| My concerns are taken seriously by my line manager | ☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly Disagree |

## Appendix 7: Social worker interview recruitment emails

**Recruitment email(s) for Phase Three interviews**
*(to be sent to participants who took part in the Phase Two online survey and indicated an interest in taking part in a follow up interview)*

*Initial email*

SUBJECT: 'Where does social work fit in mental health' – Invitation to research interview

Hello!

Last year you took part in an online survey exploring your views on mental health social work and how you felt your workplace affected your work as a mental health social worker. I'd like to take this opportunity to thank you for your time and input into the survey – it's greatly appreciated!

I'm contacting you now because, during that survey, you were asked if you would be interested in taking part in a follow-up interview to explore some of the issues in more detail and you indicated that you would. The research has now moved into the interview stage, and I would like to invite you to take part in an interview.

Interviews will focus on your role as a social worker and how you think your workplace impacts on how you undertake that. We will also talk about the policies and legislation that governs your work, and what you think the future holds for mental health social work.

Interviews will take place online (using Zoom) or via telephone, at an agreed time that suits you.

There's no obligation – if things have changed and you're unable or no longer want to take part in an interview, that's fine. Just let me know, and I'll take your details off the recruitment list.

I've attached an information sheet that gives more detail about what's involved in this phase of the research; don't hesitate to ask if you have any questions that aren't covered there.

If you're still interested in being interviewed, please reply to this email, and we can arrange a suitable interview time.

Thanks again for your involvement so far, and I look forward to hearing from you.

Regards
Laura Tucker

EMAIL SIGNATURE
ATTACHMENT: Participant Information Sheet Phase Three

*Follow up email*

SUBJECT: 'Where does social work fit in mental health' – would you still like to be involved?

Hello,

Recently I contacted you about taking part in a research interview looking at the social work role in mental health (full details and the original email are below). I haven't heard back from you and, acknowledging that time can pass quickly when you're busy, I want to check if you're still interested in taking part.

Things change, and I appreciate that – if you're no longer in a position to take part in an interview for any reason, that's fine. It would be helpful if you could let me know, so that I can recruit an alternative participant in your place.

Because this isn't about hassling you, this is the last reminder I'm going to send. If I haven't heard from you within two weeks, I'll assume that you're not able to take part, and will take you off the recruitment list. If you are still interested, please do contact me to keep your spot in the research and so that we can book your interview in.

Regards
Laura

EMAIL SIGNATURE
ATTACHMENT: Participant Information Sheet Phase Three

Appendix 8: Participant Information Sheet (social worker interviews)

# Unweaving the web: Using a mixed methods approach to understand the role and contribution of mental health social work to the delivery of mental health services in England and Wales.

**Participant Information Sheet**

Thank you for considering taking part in this research study about social work in mental health services. This information sheet is provided in order to answer any questions you might have about the study; if you want to know anything not covered here, please do contact the PhD researcher on the contact details below

**Who is undertaking the study?**

This study is being undertaken by Laura Tucker at the University of York as part of a PhD in Social Work

**What is the purpose of the study?**

Social work has a long history in mental health services, but how these services are structured has developed without a clear understanding of the contribution that social work is intended to make. Services are organised in very different ways across the country and, while some work has been done in recent years to identify key aspects of the social work role in mental health, previous research undertaken by this researcher suggests that this may not have translated easily into the varied circumstances of frontline practice.

This study aims to explore how social workers working primarily in mental health view their professional role, and how working in different parts of the country within different teams and organisations might affect these roles.

**Why have I been invited to take part?**

Earlier this year you completed a survey on social work in mental health settings. As part of this survey, you were asked if you would be interested in taking part in follow up interviews and indicated that you would. You have been selected to take part and are eligible if you are still a qualified or registered social worker in England or Wales working primarily in mental health. You do not need to be in a social work specific role, as long as a substantial portion of your clients (or the clients supported by your team in the case of social work managers) are accessing help on the basis of their mental health

**What does taking part involve?**

You will be asked to take part in one interview talking about the work that you do and your role in your team, as well as your views on social work within your particular setting. We will also talk about the policies and legislation that governs your work, and the prospects for mental health social work. The researcher will have some specific questions to ask you, but you will also be able to talk about these issues more generally.

These interviews should last no longer than one hour, and can be completed face to face or remotely by telephone or video calling. Interviews will be audio-recorded to reduce the need for note taking and to make sure that the researcher does not misunderstand your words.

**Do I have to take part?**

No – participation is entirely voluntary and you can opt out now or at any time during the interview process.

**Will I be identified in any research outputs?**

All of your identifying information will be replaced with pseudonyms in the transcripts and the original recordings erased. You will be asked to sign a consent form which will be stored in a locked filing cabinet until the end of the research, when it will be destroyed. Your interview transcript and agreement to take part in the research will not be seen by anyone other than the PhD researcher and the academic supervisor. Your employer will not be given details of any participants.

You may be quoted in the final project report and in any reports or presentations arising from this research. However, any quotes used will not include any information which could identify you and will be for illustrative purposes only.

**How will you keep my data secure?**

Any information provided in hard copy will be locked in secure filing cabinet until it is electronically scanned. It will then be destroyed. Electronic files (audio recordings, transcripts, contact information) will be secured in password protected files on the University of York secure servers. Audio recordings will be uploaded immediately following interviews, either directly to the secure servers, or, if online access is not immediately available, onto a password encrypted laptop.

**For how long will you keep my data?**

Any personal identifying data will be destroyed after three years (by September 2023 at the latest). Anonymised transcripts will be kept for ten years.

**Will you share my information with anyone else?**

Any personal information you provide will not be shared. At the end of the study, anonymised transcripts will be made available for other researchers to use provided that they can be suitably anonymised to protect your identity (you will have the option to opt out of this). For more information on your data protection, please see the data information sheet.

**Who has given approval to conduct the research?**

Ethical approval has been granted by the University of York. It has been confirmed that no approvals are needed by the Health Research Authority.

**How do I find out more information?**

PhD Researcher: **Laura Tucker**
Email: **laura.tucker@york.ac.uk**

**How do I make a complaint?**

In the first instance, please contact the academic supervisor for this study:

Academic Supervisor: **Professor Martin Webber**
Email: **martin.webber@york.ac.uk**

If you are not satisfied that your complaint has been resolved at this stage, please contact the Departmental Ethics Committee using the email address: **spsw-ethics@york.ac.uk.**

**Data Information Sheet**

**Unweaving the web: Using a mixed methods approach to understand the role and contribution of mental health social work to the delivery of mental health services in England and Wales.**

The purpose of this information sheet is to explain how your data will be used and protected, in line with GDPR.

**On what basis will you process my data?**

Under the General Data Protection Regulation (GDPR), the University must identify a legal basis for processing personal data and, where appropriate, an additional condition for processing special category data.

In line with our charter which states that we advance learning and knowledge by teaching and research, the University processes personal data for research purposes under Article 6 (1) (e) of the GDPR:

*Processing is necessary for the performance of a task carried out in the public interest*

Special category data is processed under Article 9 (2) (j):

*Processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes*

Research will only be undertaken where ethical approval has been obtained, where there is a clear public interest and where appropriate safeguards have been put in place to protect data.

In line with ethical expectations and to comply with common law duty of confidentiality, we will seek your consent to participate where appropriate. This consent will not, however, be our legal basis for processing your data under the GDPR.

**How will you use my data?**

Data will be processed for the purposes outlined in this notice and in the main information sheet. All interviews will be audio-recorded; the audio file will be transferred to the secure University of York encrypted fileserver at the earliest opportunity and then deleted from the recording device. You will be required to provide informed consent for participation. This will include your signature. These consent forms will be kept in a locked cabinet that only the researcher has access to. The anonymised findings will be analysed and included in the final thesis for assessment for the doctoral qualification. Findings will also be submitted to a journal with the aim of publication. A summary of the findings will also be shared with those who took part in the study and with local authorities and NHS trusts, as well as the Department of Health and Social Care.

**How will you keep my data secure?**
The University will put in place appropriate technical and organisational measures to protect your personal data and/or special category data. For the purposes of this project we will ensure that all audio files and interview transcripts are password protected and saved onto the secure University of York fileserver.

Information will be treated confidentiality and shared on a need-to-know basis only. The University is committed to the principle of data protection by design and default and will collect the minimum amount of data necessary for the project.

**Will you share my data with 3rd parties?**

Data will only be accessible to Laura Tucker (University of York) and the academic supervisors for the PhD. We will request that other researchers have access to the anonymised transcript for future research, but you will have the opportunity to opt out of this at the consent stage.

**Will I be identified in any research outputs?**

You will not be identified in any research output. Names will not be used. Consent will be required for us to use direct quotes in publications, but these will be untraceable back to participants. Participants do not have to consent to this.

**How long will you keep my data?**

Data will be retained in line with legal requirements or where there is a business need. Retention timeframes will be determined in line with the University's Records Retention Schedule. Anonymised transcripts will be kept for ten years from the end of the study; consent forms will be kept for three years from the end of the study; audio recordings will be deleted at the end of the study.

**What rights do I have in relation to my data?**

Under the GDPR, you have a general right of access to your data, a right to rectification, erasure, restriction, objection or portability. You also have a right to withdrawal. Please note, not all rights apply where data is processed purely for research purposes. For further information see, https://www.york.ac.uk/records-management/generaldataprotectionregulation/individualsrights/.

For this particular study, you have the right to withdraw your data up to two weeks after your interview has taken place.

**Questions**

If you have any questions about this participant information sheet or concerns about how your data is being processed, please contact martin.webber@york.ac.uk. If you are still dissatisfied, please contact the University's Acting Data Protection Officer at dataprotection@york.ac.uk.

If you are unhappy with the way in which the University has handled your personal data, you have a right to complain to the Information Commissioner's Office. For information on reporting a concern to the Information Commissioner's Office, see www.ico.org.uk/concerns.

Appendix 9: Consent form (social worker interviews)

**CONSENT FORM**

**Unweaving the web: Using a mixed methods approach to understand the role and contribution of mental health social work to the delivery of mental health services in England and Wales.**

| | **Please initial** |
|---|---|
| I have been told what this research is about and what it involves. I have been given an information sheet [dated ../../..] and have had opportunity to ask questions. | |
| I understand that I do not have to take part in the research. I am free to withdraw at any time without giving a reason and without this affecting my employment | |
| I will not be named in any research reports, and my personal information will remain confidential. | |
| I understand that if the researcher thinks that I or someone else might be at risk of harm, they may have to contact the relevant authorities, but they will try and talk to me first about the best thing to do. | |
| I agree to be audio-recorded. | |
| I understand that my words, but not my name, may be used in research reports. | |
| I understand that I will not be able to amend or withdraw information I provide once two weeks have passed since my interview | |
| I agree for my anonymous data to be archived at the University of York, and to be made available for use by other researchers | |
| I agree to take part in the research | |

Participant name:

Participant signature: Date:

Researcher signature: Date:

# Appendix 10: Social Worker Interview Topic Guide

**Unweaving the web: Using a mixed methods approach to understand the role and contribution of mental health social work to the delivery of mental health services in England and Wales.**

*Topic Guide*

1. Demographics
    - **a.** Gender, ethnicity, disability status, age?
    - **b.** Current role
    - **c.** Current team (type, scope)
    - **d.** Current employer (does this differ from team?)
    - **e.** Time qualified
    - **f.** Time spent working in mental health
    - **g.** Is social worker practicing as an Approved Mental Health Professional?
    - **h.** What encouraged you to work in mental health?

2. Perspective on your role
    - **a.** What is involved a typical day/week?
        - **i.** Anything that is social work specific?
        - **ii.** Anything that can be done by any mental health practitioner?
        - **iii.** Anything that is not a social work role?
        - **iv.** Anything that is not a mental health role?
    - b. Is there anything you do that can be/is done by other professionals?
        - i. Does being a social worker affect how you do this?
        - ii. Are there tasks best done by social workers or by other professionals? Or does professional background not matter?

3. How is your role affected by where you work?
    - a. Does the geographic area make a difference to how you work?
        - i. Which country (England or Wales)?
        - ii. What type of area (urban, rural etc)?
    - b. Does your workplace affect how you work?
        - i. The type of team
        - ii. The type of organisation (NHS, Local Authority, Third Sector etc)
        - iii. The structure of team (management & colleague responsibilities etc)
        - iv. Whether you are employed by the same organisation you work within? How does organisation structure affect how you work?
        - v. How change in the workplace/organisational change has affected your role?
    - c. What support/opportunities are available to you as a social worker in your workplace?

4. How does practice link to policy/legislation?
    - a. Health policy/legislation?
    - b. Social care policy/legislation?
    - c. Role as defined in MHSW policy (Strategic Statement)
        - i. Statutory social care and personalisation
        - ii. Recovery & social inclusion
        - iii. Working with complexity, ambiguity and risk in social and family relationships
        - iv. Working with local communities
        - v. The AMHP role

5. The way forward for mental health social work?
    - a. Do you have a path for personal career progression from your current role?
    - b. More generally for MHSWs, are there career paths available within your organisation(s)?

c. What should mental health social work involve, regardless of role or setting?

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